1-1-1992

Suicidal behavior in a population of Cape Verdean immigrant adolescents : a qualitative case study.

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SUICIDAL BEHAVIOR IN A POPULATION OF CAPE VERDEAN IMMIGRANT ADOLESCENTS A QUALITATIVE CASE STUDY

A Dissertation Presented

by

MARLENE RAE RODERIQUES

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1992

School of Education

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DEDICATION

Dedicated to the memory

of my parents

Manuel and Julia Roderiques

ACKNOWLEDGMENTS

I greatly appreciate the students who shared their life experiences with me and the professionals of New Bedford High School who participated in this dissertation study. I also want to thank the professionals of the Brockton Public Schools, the Boston Public Schools, and the many other professionals of the Brockton and Boston area who provided me with background information that enhanced my research. Your contributions are immeasurable. I want to thank my committee, Dr. Norma Jean Anderson, Dr. Diane Flaherty, and Dr. Randolph Bromery for their guidance and support during the long process of completing this doctoral program. I am also grateful to Dr. Jack Hruska, who was on my Comprehensive Committee, for his encouragement and the significant contribution he made to my research.

I must express special thanks to family members and friends for their love and confidence in me. I would like to acknowledge my son, Jay Andrade, my sister and brother-in-law, Doreene and Alfred Barber, and my aunts, Minnie De Andrade and Dorothy Grace for their very special contributions that were critical to completing this doctoral program. I must acknowledge friends who have been with me on a regular basis, who shored me up when giving up would have been preferable: Barbara Reid, Carol Almeida, Jean Athaide, and Amelia Rebeiro Ambrose. A special thanks to friends and colleagues who have given both technical

assistance and support that was critical: Joan Williams, Robert Perry, Al DeGraca and Beverly Bizzarro. I would like to especially thank my friend and colleague Ronald Barboza. The birth of the idea to study students of Cape Verde with whom I work were born of our conversations. Many journal and newspaper articles and texts on Cape Verde that are an integral part of this dissertation came from his private collection. Ron spent a great deal of time with me sharing his extensive knowledge about the history and culture of our ancestral homeland. There are no words to express my gratitude for his contribution to this dissertation. There are numerous other family members, friends, and colleagues who were there along the way; without all of you the culmination of my work would not have been possible.

This researcher would also like to offer the following acknowledgement:

There is very little written about the Cape Verdean immigrant community in the United States and the Cape Verdean-American community of first, second, and third generations, etc. We are not a well known ethnic group. For this reason, it was somewhat of a concern that my focus on a very serious problem exposed a great many negative aspects of life for some of the young people and their families. In no way should these negative life experiences be viewed by the reader as representative of the community as a whole.

I am most proud of my Cape Verdean heritage. We are a strong, proud, and gifted people who have enriched America in many ways. However, for many of the people of this tiny nation life has not been easy, and they have struggled for their very survival. Survival often meant coming to America. In so doing a good number of the courageous immigrants who sought a new life in the United States experienced tremendous problems in the process. The difficulties in some families, and in the adjustment process itself, meant crises such as the sad experiences of the suicidal youth depicted in this dissertation.

I sincerely hope that the decision to explore this mental health phenomenon in the Cape Verdean immigrant community will lead to a positive approach to addressing this issue and ultimately contribute in a positive way to the realization of the better life for which many left their homeland.

ABSTRACT

SUICIDAL BEHAVIOR IN A POPULATION OF

CAPE VERDEAN IMMIGRANT ADOLESCENTS

A QUALITATIVE CASE STUDY

MAY 1992

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This qualitative case study identified possible causal/contributing factors in the suicidal behavior of several cases of Cape Verdean immigrant adolescents, and identified commonalities in this target group. Three Cape Verdean immigrant adolescent students who had manifested serious suicidal behavior, and three Cape Verdean immigrant adolescent students who had not exhibited such behavior participated in the study. A qualitative case study approach was utilized. The methodology of interviews and observations was employed. Students who had manifested serious suicidal behavior, were compared to each other and to students who had not exhibited suicidal behavior.

The following research questions guided this study:

1. What possible causal/contributing factors are present in the case studies of students who had been suicidal?

2. What are the precipitating events in these cases of suicidal behavior?
3. Are there any commonalities in the causal/contributing factors in each of the cases studied?
4. What differences are noted when a comparison is made between the group of students that has exhibited suicidal behavior and the group that has not.

It is this researcher's opinion that to a large degree, the Cape Verdean immigrant adolescents in this study exhibited suicidal behavior for the very same reasons that other young people manifest these behaviors. Serious family conflict, loss of loved ones through death and separation, feelings of isolation and rejection from family members and peers, and a lack of connectedness to a significant caretaker may have been the most overwhelming contributing factors. However, their experiences with emigration, culture shock, and racial/cultural/linguistic differences may have added just enough additional stressors to predispose them to a greater degree to suicidal behavior when the other more typical causal/contributing factors were present.

The critical implication of the data from this study is that communities and schools need to join with families of the Cape Verdean immigrant population to develop strategies and programs to remedy this serious mental health issue.

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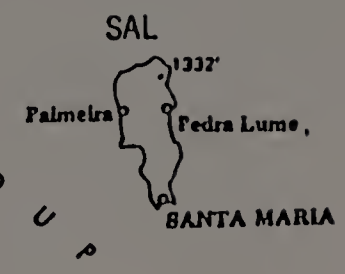

CHAPTER 1

INTRODUCTION

Statement of the Problem

The adolescent suicide phenomenon, with its overwhelming statistics today, has educators, mental health professionals, sociologists, parents and all concerned citizens crying out for an answer to this perplexing youth catastrophe. For the adolescent population as a whole, the statistics reveal that some 5,000-6,000 teens a year are taking their lives; and for <u>each</u> of these known fatalities, 100 suicide attempts are suggesting the same dissatisfaction with life. (Barrett, 1989).

A subgroup of the general teen population has further alarmed the adult caretakers; youth of color and culturally different youth are opting for suicide and self-destructive behavior at rapidly increasing rates to remedy the malaise in their lives. Experts in the field maintain that racial and ethnic differences and cultural changes can be sources of vulnerability.

According to Gibbs (1988, in Maris, ed.) suicide is the third leading cause of death of Black youths age 15-24. It is exceeded only by accidents and homicides. From 1960-1983 the suicide rate for Black youths aged 15-24 doubled for Black females (from 1.3 to 2.7 per 100,000) and nearly

tripled for Black males (from 4.1 to 11.5 per 100,000). Klagsbrun (1976) states that in New York City young Black males commit suicide twice as frequently as young Whites. This trend is beginning to appear in other large urban areas as well.

Herbert Hendin in his classic text, Black Suicide, concludes that the impact of racist institutions seems to be felt so early in life that by the time Blacks reach the teen years they already exhibit the frustration, rage, violence and despair that are often forerunners to the suicidal crisis.

Grollman (1988) characterizes adolescent suicide among Native Americans as a virtual epidemic and reports the findings of Dr. Harry L. Dizmany who investigated this group. According to Dr. Dizmany's findings:

> The Native American youth is caught between two cultures: one for which he is unprepared, the other which he feels has failed him and toward which he has a deep ambivalence. He is neither an Indian with a sense of pride and respect for his people and his culture, nor an assimilated outsider able to identify with the culture and traditions of the dominant group (Grollman, 1988, p.50).

Hafen (1986) reports that the suicide rate for Native American adolescents on reservations has increased 200-300 per cent.

According to Grollman (1988) language and cultural differences in the Hispanic population are contributing factors to the increasing incidence of Hispanic youth suicide. The extended family network common to Hispanic

groups prior to their migration to urban centers in mainland United States is no longer available to assist the troubled adolescent.

> Children of newly immigrant families were seen as caught between conflicting cultural values and patterns and as prone to isolation from peers and alienation from parents (Grob et al., 1983, p. 168).

New Bedford has a population of approximately 106,000. Over 50% of the population is Portuguese immigrant or first generation Portuguese. The strict, overprotecting Portuguese immigrant parents often do not allow their teenage daughters to socialize in what is perceived as a society which allows too much freedom for young people. A number of Portuguese, Hispanic, and Cape Verdean young women counseled by this author at New Bedford High School were severely depressed and/or suicidal partly due to this reason.

The Cape Verdean, Portuguese, and Hispanic immigrant students are examples of the racial and ethnic aspect of the youth suicide phenomenon. This researcher will focus on the problem of adolescent suicidal behavior in a little known racial/ethnic minority group heavily concentrated in Southeastern Massachusetts. The Cape Verdean community is concerned about the increasing incidence of suicidal behavior in both the adult and adolescent population. As a second generation Cape Verdean American professional with both personal and professional interests in studying this phenomenon, this researcher hopes that this study will make

a positive contribution toward ameliorating this mental health problem in this ethnic group.

Cape Verdeans are a multi-racial people, primarily descendants of West African slaves and the Portuguese settlers who first settled on the islands in 1462. Official Portuguese documents record the discovery of Cape Verde by the Portugal in 1460. Shortly after the Portuguese settled on Cape Verde, they transported African slaves from the west coast of Africa to work what would prove to be barren land. Eventually the Cape Verdean culture was born through the complex interaction of miscegenation. The language of the Cape Verdean people is Crioulo, a dialect of Portuguese with a heavy African influence. The culture of the Cape Verdeans reflect the Portuguese primarily; however, there is also a discernible African influence. For 500 years the Cape Verde archipelago was considered an overseas province of Portugal, however, on July 5, 1975, Cape Verde became an independent nation. Cape Verdeans have been emigrating to the United States for approximately 200 years. Today there are about 350,000 Cape Verdean-Americans. The first discernible numbers of Cape Verdeans to reach America came aboard whaling vessels as crew members.

Today Cape Verdeans are still coming to America, with many of them settling in New Bedford, Massachusetts, which has one of the largest Cape Verdean communities in this country. New Bedford has often been referred to as the Cape

Verdean capital of the United States. "Cape Verdean-Americans are estimated at some 20,000 in the Providence-New Bedford area" (Meintel 1984 p.13). However, other sources estimate that New Bedford alone has over 17,000 Cape Verdean residents (Barboza, Personal Communication, 4/18/92).

New Bedford High School provides bilingual education to Cape Verdean immigrant adolescents. Although this author has been a crisis counselor at New Bedford High School for the past fourteen years, it was not until the 1988-1989 academic year that immigrant Cape Verdean students were referred with suicidal behavior as the presenting problem. That year one female student was referred as a result of expressing suicidal ideation. By November 1990, only three months into this school year, five referrals of female Cape Verdean immigrant adolescents had been referred for suicidal behavior. Considering that the October 1990 school census report listed 66 students as Cape Verdean in the bilingual program, that was nearly 10% of this group.

During the 1990-1991 academic year six refferals of Cape Verdean immigrant adolescent females were made to the Crisis Center at New Bedford High School; three presented as suicidal and three had attempted suicide by self-poisoning, necessitating brief hospitalization. The issues that preciptated this extreme response to personal problems will be explored fully in Chapters II, IV and V.

Adolescent suicidal behavior in the Cape Verdean immigrant population is as tragic situation and clearly indicates that investigation of the problem is imperative.

The Purpose

The purpose of this qualitative case study is to identify possible causal/contributing factors of the suicidal behavior in several cases of Cape Verdean immigrant adolescents, and to determine if commonalities exist in this target group.

Research Questions

1. What possible causal/contributing factors are present in the case studies?
2. What are the precipitating events in these cases of suicidal behavior?
3. Are there any commonalities in the causal/contributing factors in each of the cases studied?
4. What differences are noted when a comparison is made between the group of students who have exhibited suicidal behavior and the group that has not exhibited such behavior?

The units of analysis of this multiple-case study include six students, three who have manifested serious suicidal behavior, and a comparison group of three students who have not exhibited suicidal behavior. Admittedly six students constitute a small study, and this is an obvious limitation when one considers traditional research. However, this small group has been chosen purposefully for the richness of information that it will provide.

To substantiate the soundness of the approach, this researcher offers the following insights by experts in the field of Qualitative Research and Case Study Methodology.

> ...case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study, like the experiment, does not represent a 'sample,' and the investigator's goal is to expand and generalize theories **(analytic generalization)** and not to enumerate frequencies **(statistical generalization)** (Yin, 1989, p.21).

Patton (1987) states that:

> Case studies become particularly useful where one needs to understand some particular problem or situation in great depth, and where one can identify cases rich in information; rich in the sense that a great deal can be learned from a few exemplars of the phenomenon in question (p. 19).

A serious limitation of any study involving adolescents is the possibility that some information that is self-reported may be a misrepresentation of facts or feelings. Responses from additional sources (triangulation) were helpful in better understanding each case.

Additionally this researcher had several sessions with each student. When responses were questionable, questions were asked somewhat differently or indirectly during a subsequent session.

Significance

There is a paucity of research on suicidal behavior of minority populations in general, and in minority adolescent populations as a sub-group. Grollman (1988), Klagsbrun (1976), Hendin (1969 & 1982), Gibbs (in Maris, ed. 1988) are merely a few of the experts who expressed concern over the increasing problem of adolescent suicide in youth of color and the need for research addressing this mental health phenomenon in these populations. Gibbs statements that highlighted this problem basically summarize the sentiments of his colleagues when he criticized the fact that the literature on Black youth suicide provides limited conceptual approaches, a minimum of clinical investigations, and a paucity of empirical studies. Grollman (1988) addressed this lack of information with Hispanics as did others with this mental health problem in the American Indian population. Copeland sums it up rather well, "Future research concerning suicide among non-whites is imperative. ... the loss to the community is great, especially if the

victim is young. ...high risk nonwhite groups must be protected from suicide and studied further." (1989, p.13).

The literature search undertaken by this researcher was disappointing with regard to this aspect of adolescent suicide.

To date there are no completed studies in the Cape Verdean population specifically. Considering that this appears to be a growing mental health problem for this ethnic group, the study could have a positive impact on improving this tragic situation. Additionally, the findings may have implications for suicidal behavior in other racial/ethnic groups.

This researcher has responded professionally to similar suicidal behavior issues in other cases involving immigrant adolescent Portuguese and Hispanic females who frequently succumb to the stressful conflicts inherent in their dual world existence. In addition to concerns for these groups, this nation is being deluged with new immigrant groups presenting myriad social/psychological problems. Perhaps this study would provide implications for Haitian, Cambodian, Mexican-Americano, Viet-Namese and other immigrant communities as well, if there exists suicidal behavior in their youth population.

Marshall and Rossman (1989 p.32) point out that "a study's importance can also be argued through summaries of the writings of informed experts who identify the topic as

important and call for research persuing the general questions. Both statistical presentations of incidence and calls for research by experts demonstrate that the study addresses an important topic, one of concern to policymakers and practitioners in that area."

With the aforementioned in mind, it is appropriate to add the following statement by Antonio Gonsalves of the Brockton Public Schools, a professional who is also concerned about the problem of suicidal behavior amongst Cape Verdean immigrant adolescents.

> I am very pleased that you are doing your dissertation with this particular focus. It's not a documented problem. I'll tell you very clearly that if you speak to some first generation individuals, I'm not sure that they see suicide as a real problem either. I could count people, Cape Verdeans who have said to me 'they wished they were dead,' or 'something is going to happen to me,' or who have given me some verbal indication that their life was going to end, and it did end, but could never be pointed clearly to suicide; and these are kids that I could count that I've worked with in the city of Brockton.

Mr. Gonsalves emphasized that merely looking at overt suicidal behavior did not tell the whole story.

Primary Sources

Since the literature review undertaken for this dissertation was devoid of specific information on the problem of suicidal behavior in the Cape Verdean adolescent population, save one newspaper article highlighting the problem in Boston, this researcher decided to seek out

primary sources knowledgeable about and familiar with Cape Verdean families and/or Cape Verdean adolescents outside of the New Bedford area, in order to substantiate the concerns and perhaps provide further indication of suicidal behavior in this ethnic community. It became imperative for this researcher to determine if indeed there was a problem of adolescent suicidal behavior in immigrant Cape Verdean communities outside the city of New Bedford and just how significant the problem was in the opinion of individuals qualified to offer an informed perspective. It is significant to point out that only background information on the subject was sought from these primary sources; it was not the intention of this researcher to involve students or particular case studies of suicidal behavior other than those in the study completed at New Bedford High School.

Brockton, Massachusetts was especially selected as an interview site because of the large Cape Verdean immigrant population, and because it is a city that is very close in size to New Bedford. This researcher sought information on the subject that would provide further evidence of the problem if it in fact existed outside the purview of this researcher, and additional information, insights, conclusions and recommendations that would enhance this dissertation study.

Joe Evora, an administrator in the Brockton Public Schools, provided excellent background information on Brockton's Cape Verdean community:

> I would say 7500 people is a decent, maybe conservative estimate of the Cape Verdeans in Brockton. The majority of the Cape Verdeans living in Brockton are new immigrants. Brockton is not like New Bedford (which has a larger second/third generation population, about 20,000, and smaller, approximately 2000, immigrant population); we have some few first and second generations in Brockton, but you could count those families on two hands. It's said that about ten years ago there were about 3,000 minorities in Brockton. If you go to the high school you'll find that the officially accepted statistic is that minorities comprise 30-40% of the population, but if you look around you, you will see that it's around 50%; that's my perspective. But if you go to some elementary schools you will find about 70% of the school population is minority. I refer to the Afro-American, Hispanic, Cape Verdean, Haitian and Asian. In 1991 the graduating class from Brockton High School had 12% Cape Verdeans. The Cape Verdean population is the largest minority population in this town.

The present population of Brockton is 97,429. There are approximately 500 Cape Verdean bilingual students at Brockton High School and a total of 942 students in the Brockton Public Schools with Crioulo as their first language. The Student population of Brockton Public Schools is 14,000 and approximately 3200 of those students attend Brockton High School.

Several professionals and a clergyman, who have considerable knowledge and experience in the Boston, Massachusetts (Roxbury/Dorchester) Cape Verdean immigrant population also offered significant information. Padre Pio estimated this immigrant community to be about 8000-10,000

people in a city with a population of 574,283 people. The October 1991 school census of Boston listed 874 students in the Cape Verdean bilingual program.

The following individuals were interviewed and shared relevant information from their experiences. The information provided by some professionals corroborates this researcher's findings and concerns; however, some professionals did not share the view that suicial behavior was a problem in the Cape Verdean immigrant community.

A biographical sketch of the participants as well as the essence of their viewpoints, for those who had a definite opinion on this issue, are offered. Findings from these interviews will also be interspersed throughout the dissertation as appropriate. These individuals made a tremendous contribution to this dissertation, and this writer is deeply indebted to them.

Carol Almeida

Ms. Almeida, a second generation Cape-Verdean American, lived in New Bedford for about 15 years before moving to Boston when she was a sophomore in high school. She spent the next thirty years in Boston before returning to New Bedford in 1990. She is the Chief Supervising Nurse for the Boston Public Schools and has been in this position for the past five years. Prior to this position she was a school nurse for six years in Boston. While in this latter

position she initiated a counseling program that served high risk adolescent girls, including a number of Cape Verdean immigrant adolescent females. By virtue of her close involvement in the Cape Verdean community and her experiences with the students in the Boston Public Schools as a professional, Ms. Almeida developed a cultural awareness of her people and a concern for health issues (including mental health issues) of the Cape Verdean people.

Ronald Barboza

Ronald Barboza is a second generation Cape Verdean-American who has been a teacher in the New Bedford School System for twenty-three years. He has been on the New Bedford High School faculty for the past eighteen years. His personal collection of articles and texts on Cape Verde constitutes a library that no doubt is the only privately owned collection of its kind. Mr. Barboza has traveled to Cape Verde six times, and he has photographed all of the islands. His photographs have been published in numerous newspapers and magazines. They enhance the walls of the Cape Verde Embassy in Washington, D.C., as well as many New Bedford buildings and homes. Mr. Barboza has studied his spiritual island home and the heritage of his people with a passion that eludes description. He is sought after to speak on Cape Verde and present his famous slide shows to public and private groups all around New England. His

passion for knowledge about his ethnic group is only exceeded by his willingness to share it with others. This researcher was priveleged to have been given at least a four hour orientation/preparation by Mr. Barboza for her first "journey home" to Cape Verde, which included videotapes and private lectures on the specific islands, as well as the necessary precautions to novice travelers in third world countries. Ronald Barboza contributed much information to the overview on Cape Verde.

Alcides DeGraca

Mr. DeGraca is a Cape Verdean bilingual teacher at New Bedford High School, where he has been on the faculty for fifteen years. He is very familiar with the Cape Verdean immigrant students in this community. He was born in Brava, Cape Verde and came to this country in 1967 at the age of nine years, and lived in the Boston Cape Verdean immigrant community for approximately 1 1/2 years. The family then moved to Taunton, where he has resided ever since. Mr. DeGraca attended schools in this country as a bilingual student initially; by virtue of this experience he is able to understand the experiences of the students he serves and assist them in the acclimation process. This researcher has been a colleague of Mr. DeGraca for many years and cannot underestimate the tremendous contribution he makes to his students that go far beyond meeting their academic needs.

According to many of his students personal statements, it is obvious that he is extremely well-respected and appreciated by the young people he serves in the New Bedford Public School System. He offered considerable information on the culture and history of the islands he still calls home, and contributed insights on the subject of suicidal behavior of Cape Verdean immigrant adolescents.

Jose Evora

Jose (Joe) Evora is the Director of Title VII, a federally funded program in the Brockton Public Schools. He was born in the Cape Verde Islands and was educated in Cape Verde and Lisbon, Portugal, where he received a degree in Public Health and Safety. Mr. Evora worked for the Portuguese government in Lisbon, as well as in Angola. He first came to the United States in 1966 and eventually settled in the United States in 1975. Mr. Evora was very involved with the Cape Verdean community in Scituate, where he began his professional career as a community liaison. He was also instrumental in the establishment of the Cape Verdean bilingual progam in this town.

Antonio Gonsalves

Antonio (Tony) Gonsalves is a School Adjustment/Guidance Counselor working at Brockton High School. He has served as an adjustment counselor for the mainstream, as well as the

Cape Verdean population in the city of Brockton. Mr. Gonsalves is a third generation Cape-Verdean American who was raised in the Duxbury/Marshfield area. He has considerable experience with his cultural group and has spent time in Cape Verde, Guinea-Bissau and Western Africa. Mr. Gonsalves was very involved in the Cape Verdean struggle for independence, primarily through supportive activities here in the United States.

Daniel M. Hirsch

Daniel M. Hirsch was the Consulate of the United States of America in Cape Verde at the time of this writer's trip to the island republic in August 1989. On August 18, 1989 he agreed to an interview at the American Embassy in the capitol of Cape Verde, Praia, which is on the island of Santiago. Mr. Hirsch was extremely gracious and shared a great deal of information on the islands, her people, and recent developments in the history of this young nation.

Dr. John McNamara

Dr. McNamara is the Chief of Pediatrics at Brockton Hospital where the Brockton Children and Youth Project serves as a primary medical resource for the Cape Verdean immigrant community. Dr. McNamara is involved with adolescents who avail themselves of project services. Dr. McNamara and

associates also run the school health program at Brockton High School.

Vernon Penner

Vernon Penner was the Ambassador to Cape Verde at the time of this writer's trip to the islands in August 1989. During a visit to the ambassador's residence, he graciously offered a great deal of information on Cape Verde. In addition to answering numerous questions on the islands and US-Cape Verde relations, the ambassador provided this researcher with a very helpful information packet, which contributed to the overview of Cape Verde comprising Part II of the literature review in the second chapter of this dissertation.

Joao Pereira

Joao Pereira is an adjustment counselor in the Brockton Public Schools for grades K-8, and works with the Cape Verdean population. He comes in contact with young adolescents in his present assignment, and he previously worked one year at the high school. Mr. Pereira is also involved with Cape Verdean immigrants in his private practice at a New Bedford clinic offering psychotherapeutic services to the Cape Verdean, Portuguese, and Hispanic communities; he speaks Portuguese, Spanish and Crioulo.

Alcides Pina

Alcides Pina emigrated to the United States in 1977 at the age of 15. He graduated from Brockton High School, and is a product of the city's Transitional Bilingual Program. A 1986 graduate of Bridgewater State College, he was hired by the Brockton Public Schools. Mr. Pina was a school adjustment/guidance counselor for Brockton High School from 1986-1988 and from 1989-1991. His caseload was 95% Cape Verdean immigrant adolescents. In 1989 Mr. Pina worked as a case worker for the MSPCC (Massachusetts Society for the Prevention of Cruelty to Children), a private agency that contracts work for the Department of Social Services in the city of Boston. In this position he was very involved with Cape Verdean immigrant adolescents in the Roxbury and Dorchester area.

Padre Pio

Padre Pio is a Catholic priest who was born in Italy and went to Cape Verde in March 1949 to begin his long involvement with the people of Cape Verde. Padre Pio, who is virtually an institution in the Cape Verdean communities of New England, has spent a total of forty-three years ministering to the people of this island republic. He visited America in 1977, and in 1979 Cardinal Medeiros, whom he had met while in the US, invited him to come and serve the Cape Verdean communities in the greater Boston area,

following the death of the priest who served the immigrant community at that time. Padre Pio of St. Patrick's Church in Roxbury says mass in Crioulo at Our Lady of the Assumption Church in New Bedford once a month and in Scituate once a month. He ministers to the Cape Verdean community in Brockton twice a week. Semi-annual religious services are conducted by him in Crioulo in the Cape Verdean communities of Bridgeport, Connecticut, New Jersey, and Sacramento, California. Padre Pio over many years has been a part of the lives of many Cape Verdean families and has rightfully become a revered individual in the hearts and minds of Cape Verdeans, wherever they reside.

Dr. Maria Rodrigues

Dr. Roderiques is a physician with a specialty in infectious diseases. She is presently involved in post residency training with a Brown University fellowship. Dr. Rodrigues is practicing in Brown University affiliated hospitals in Rhode Island. She was born in Atalia, Fogo, and came to the US in 1967 at age 7 1/2 years. Dr. Rodrigues lived in the Roxbury/Dorchester Cape Verdean immigrant community for most of the years that she has spent in this country, and speaks very knowledgeably about her ethnic group and this particular immigrant community. She shared her thoughts and concerns about the incidence of suicide and suicidal behavior in this community.

Essentially, Dr. McNamara, Padre Pio, and Joao Pereira, did not share my view that a problem of suicidal behavior existed in the Cape Verdean immigrant community.

Padre Pio informed this researcher that he has not seen a problem of suicidal behavior amongst Cape Verdean immigrant teenagers in Boston, "mostly with older people. They can't adjust to the lifestyle here in the US, and they can't go back to their country because they've given up everything to come here." He did recall one young women several years ago who ingested medication over a broken relationship.

Joao Pereira, who also had an opposing view, said that:

> As far as I know about the Cape Verdean population in Brockton, there are not too many cases where we can say that Cape Verdeans are killing themselves. Primarily it is not part of the culture.

Carol Almeida, Antonio Gonsalves, and Alcides Pina did share this author's concern that suicidal behavior in Cape Verdean immigrant adolescents was a concern. Although Dr. Rodrigues was unfamiliar with suicidal behavior in adolescents, she shared knowledge of completed suicides in adults in the Boston immigrant community. One such adult who was in his early twenties would be considered still in the adolescent stage of development by some experts who consider this developmental stage to continue into the early twenties.

Alcides Pina spoke about a number of contributing factors in the suicidal behavior in this population.

Amongst those problms that he cited, was the special problem of females, since he had more cases of females exhibiting suicidal behavor.

> Males and females receive different treatment from their parents. I think that a lot of times when they come here and are educated that we are all the same it causes conflicts. As females become very alienated, they feel that they are unwanted; they feel that they are unloved and they feel that they are not important. And this will cause them in many instances to exhibit suicidal behavior. I dealt specifically with these types of cases.

Antonio Gonsalves had an interesting perspective on suicidal behavior that paralleled this researcher's experiences to some degree. However, given the experience he has had in a much larger immigrant population, he offered considerable insight into other aspects not experienced by this writer. His experiences suggest that this mental health problem in the immigrant community is even greater than originally suspected.

> Over the last ten years especially I have found that Cape Verdean adolescents, like any other adolescent, has a real problem with peer pressure. And the Cape Verdean has a problem that is magnified in the sense that generally there are some ego deficits in terms of accepting themselves within this new culture, this new society which causes a lot of those youngsters in that situation to overreact, so that they try to become, if you will, more American than the American; so that this creates a double-barrelled problem in the sense that the same types of stimuli that affect and pressure the mainstream, the American born to commit suicide, whether it be drugs, whether it be alcohol or dysfunctional family background, or whether it's because of a love affair that's gone bad, or because of disappointments in the education that they thought they could get or jobs, the whole bailey-wick of things. The Cape Verdean kids suffer those same things, but in some ways it's more intense and magnified by the Cape Verdean immigrant population due to their additional

problems. Interesting enough, most Cape Verdeans, I'm not sure of the numbers, but in many Cape Verdean suicides, they are not the typical type of suicides that you will find in the mainstream where they hang themselves, or they shoot themselves or they cut their wrists or something like that. Generally what they do is over take of something such as a drug; they are aware of this, and so they kill themselves with an overdose, for example. So that is no longer put down as a suicide; they put down that the person od'd or something like this. But I do know of cases where youngsters have been killed in automobile accidents; but I am quite sure based on conversations or experiences with that particular person that it was suicide. Many people commit a social suicide or a system suicide where they continue to live, but they now put themselves in positions where they are prostitutes or drug dealers or gang members, and so forth. At some point 'the external will kill me; I won't have to kill myself.' I'm telling you that through the standard means of perception generally utilized in this type of study, you would not uncover any problem at all, period. (personal communication 1/8/92).

If Antonio Gonsalves observations are closer to the real problem of suicidal behavior in this population, and this researcher believes that might be, it explains why the problem is not readily recognized amongst Cape Verdean young people by the professionals working with these youth, the Cape Verdean community itself, and the larger community.

Definitions

Noted experts in the field of **Suicidology** have made possible a greater understanding of this complex mental health phenomenon by providing terms and definitions of **Suicide** that clarify and illustrate the often subtle nuances on the full continuum of suicidal behavior.

In addition to the definitions of suicidal behavior, a number of other significant terms are clarified for the purposes of this study.

Adolescence is identified as the period of an individual's life from the onset of puberty to adulthood. The corresponding chronological age range is from approximately the early teens to the early twenties.

Suicide is the human act of self-inflicted, self-intentioned cessation (Shneidman, 1985).

"According to Durkheim, suicide is the result of society's strength or weakness of control over the individual. Durkheim posited four basic types of suicide, each a result of man's relationship to his society:

1. **altruistic suicide**: in this type of suicide society exerts control over the individual through norms, values, and rituals, leaving little room for freedom of the individual; e.g. Japanese **hara-kiri**.
2. **egoistic suicide**: egoistic suicide occurs when an individual's ties to his community are too few or too tenuous; demands to live do not reach him.
3. **anomic suicide**: a kind of aloneness or estrangement that occurs when an accustomed relationship between an individual and his society

is precipitously disrupted or shattered; e.g. loss of a job, friend, fortune.

4. **fatalistic suicide**: the result of excessive regulation of the individual; no personal freedom and no hope; e.g. the suicide of slaves or Jews in Nazi concentration camps.

Thomas E. Hill, Jr. (1983) focuses on 4 defined types of suicide:

1. **impulsive suicide** is prompted by a temporarily intense, yet passing desire or emotion out of keeping with the more permanent character, preferences and emotional state of the agent.
2. **apathetic suicide** - an extremely depressed person who simply does not care about the future; emptiness.
3. **self-abasing suicide** - results from a sense of worthlessness; one's life is seen as having a negative value.
4. **hedonistic calculated suicide** - a cost/benefit calculation; choice determined by estimate of balance of pleasure and pain one expects from the choice.

"The notion of **subintentioned deaths** (Shneidman, 1973,1981) was meant to describe those deaths-perhaps a majority of all deaths in which the decedent has played a

covert, partial, latent, unconscious role in hastening his own death."

Parasuicide describes a situation when an individual executes a non-lethal, self-inflicted, injurious, suicide-like act (Shneidman, 1985).

The types of self-injury that occur in **attempted suicide** can be divided into three broad categories (Hawton & Catalan, 1982):

1. **Superficial self-cutting** - usually on wrist or forearm; there is usually little or no suicidal intent; typically cuts are superficial; repeated self-cutting is common and appears to be associated with eating disorders and with alcohol and drug abuse. The usual precipitants are actual or threatened loss or an impasse in a personal relationship (Simpson, 1975).
2. **Serious self-injury** - includes hanging, jumping from heights, in front of vehicles, as well as deep cutting of the throat and neck. These methods are more often boys-almost always with serious suicidal intent.
3. **Self-mutilation** - damage to the genitals or to the eyes-rare in young people-result of serious psychiatric disorder, including schizophrenia in which the mutilation may occur as a consequence of a delusional belief or a hallucinatory command.

4. Deliberate self-poisoning - "...overdoses by children and adolescents are mostly taken very impulsively, with maybe little more than a few minutes forethought."

Indirect suicide was labeled 'symbolic suicide' by Emile Durkheim (1897).

Karle Menninger called 'indirect suicide' 'chronic suicide' when an individual employed indirect, self-destructive behavior that undermined his own health.

Calvin Frederick of the National Institute of Mental Health cites seven prominent characteristics of indirect suicide (Grollman, 1988):

1. there is a lack of full awareness of the consequences.
2. the behavior is rationalized, intellectualized, or denied.
3. the onset could be gradual, but death is precipitous
4. open discussion seldom occurs.
5. long suffering, martyrlike behavior may appear.
6. secondary gain is obtained by evoking sympathy and/or expressing hostility via the process.
7. death is most often seen as accidental.

Autocide is the term used for suspicious automobile accidents that frequently are one car collisions; the car is an ideal instrument of self-annihilation (Grollman, 1988).

Suicidal Behavior

a. **Suicidal Ideation:** Suicidal ideation is the serious contemplation of ending one's life, but not having actually threatened/attempted suicide.

b. **Threatening Suicide:** Threatening suicide refers to an individual telling someone that he/she is going to kill him/herself.

c. **Attempted Suicide:** Attempted suicide refers to the action when one acts purposefully to end his/her life by some means, e.g. ingesting medications, substances toxic to humans, shooting self, etc.

d. **Completed Suicide:** Completed suicide refers to the ending of one's life by self-inflicted injury.

Cape Verdean Immigrant Adolescent: For the purposes of this dissertation, **Cape Verdean Immigrant Adolescent** refers to students who were born in the Republic of Cape Verde, whose parents were born in the Republic of Cape Verde, who emigrated to the United States not speaking English, and who had to begin schooling in this country in a Cape Verdean bilingual class. The student is between 13 years and 19 years of age.

CHAPTER 2

REVIEW OF THE LITERATURE

The review of the literature is essentially a two part review. Part I is the reiview of the literature on **suicide and adolescent suicide**; Part II is a review of the literature on **Cape Verde** which provides a very necessary overview of the island republic and her people. The history and culture of this ethnic group shape the lives of the students studied, and knowledge of this unique people is extremely critical in order to fully understand the context of suicidal behavior in this adolescent population. Alcides Pina (Personal Communication, 12/11/91) expressed this point quite well, "Whenever you talk about suicide among adolescents in the immigrant population, you have to go back to Cape Verde and talk about the political, social, and economic problems in Cape Verde."

This researcher is also presenting findings from interviews with professionals who have an extensive background working with Cape Verdean immigrant families and adolescents in the city of Brockton, Massachusetts. Three of the professionals also have experience in the Cape Verdean immigrant community of Boston, Massachusetts.

Adolescent Suicide

Theories of Suicide

A theoretical framework is offered to provide a foundation for this treatise on **suicidal behavior.** No one theory can explain suicide in general, nor adolescent suicide specifically. Research findings over many years, offered by innumerable experts indicate that there does not exist a clear causal relationship in suicide. The suicide/suicidal behavior of each person must be examined in light of all the variables and complex factors that make up the life experience of the individual.

Theorists from various disciplines provide their perspectives on suicidal behavior in general, while a select group of theorists offer differing paradigms specific to adolescent suicide. A summary of a representative number of theoretical models follows.

Sociological Theory - Emile Durkheim

Durkheim's pioneering effort on the subject of suicide, Le Suicide (1897), asserted that suicide was an individual phenomenon and was man's reaction to the peculiarities of

society. Durkheim saw suicide as a type of destructive behavior that can result from the type of control that society has over man.

Durkheim delineated four types of suicide (defined in the section containing terms relating to suicide): 1) egoistic-man is alienated from community, family, friends. 2) anomic-failure of person to adjust to social change. 3) altruistic suicide-group authority over individual is so compelling individual loses identity and sacrifices the self. 4) fatalistic-rules and regulation of society allow for no personal freedom, no hope.

Psychoanalytic Theory - Sigmund Freud

Sigmund Freud's contribution to the study of suicide was his psychoanalytic theory that would also serve to influence the future work of other theorists.

"According to Freud, suicide is a highly convoluted process related to depression and pathological mourning" (Orbach, 1988, p.14). This process stems from an ambivalent love-hate reaction toward a lost love object through rejection, death, or separation. Anger toward the lost love object becomes aggression turned inward.

"His essay 'Mourning and Melancholia' presents his theory of suicide. There are two kinds of drives: one is the life instinct or Eros; the other is the drive toward

death, destruction, and aggression, or Thanatos" (Grollman, 1988, p. 27). For Freud, death is more than a bodily event. Death is willed. There is a constant shifting of the balance of power of the two instincts. Suicide is aggression turned upon the self. Freud's theory is often summarized in the following statement: 'Suicide is murder in the 180th degree.' Freud's implicit value judgement is that murder is to be disapproved and prevented. Suicide, too, is murder turned about and must also be disapproved and prevented.

Karl Menninger

Menninger builds on Freud's theory. He believes that the tension that exists in life is the conflict between the instinct of self-preservation and the instinct toward self-destruction.

In the opinion of this theorist there are deeper motives related to suicide (Grollman, 1988):

1. There is the wish to kill.
2. There is the wish to be killed.
3. There is the wish to die.

Alfred Adler

> To be a human being means to feel inferior. Suicide signifies a veiled attack upon others. Through an act of self-destruction, they hope to evoke sympathy for themselves and cast reproach upon those responsible for their lack of self-esteem. Adler described suicidal persons as inferiority ridden people who "hurt others

by dreaming themselves into injuries or by administering them to themselves" (Grollman, 1988, p. 28).

Norman Faberow

The Many Faces of Suicide (1980) by Faberow is a classic text in the field of Suicidology.

> Faberow was the first to define and systematically examine those forms of self-destructive behavior which are not generally classified as suicidal, such as substance abuse, including drugs, alcohol, and tobacco; physical illness such as cardiac conditions and spinal injuries where patients disregard their prescribed medical regimen; crime, prostitution, delinquency, compulsive gambling . . . and high-risk sports such as skydiving, hang gliding and scuba diving (Orbach, 1988 p. 16).

Phenomenological Approach - Edwin Shneidman

Shneidman theorizes that suicide is the product of a suicidal lifestyle.

> The suicidal lifestyle is characterized by hostility toward the self and others. The suicidal person does not love himself, is persistently pessimistic and cannot enjoy himself or those surrounding him. He is in continual conflict with his environment (Orbach, 1988, p. 16).

Theory of the Suicidal Career - Ronald Maris

Individuals exhibiting the suicidal career are persons who refuse to accept the conditions of their life. Generally they cannot find, or refuse to discover workable alternatives to suicide. They may employ non-suicidal coping methods such as alcoholism, isolation, violence,

drugs, risk taking, which still border on suicide in that they lead toward self-destruction (Orbach, 1988).

Biochemical Model

This model looks to genetic and biochemical variables to explain suicide. The biological components of depression and direct genetic influences are included in the search for explanations to suicide.

Reiner (1984) has explored genetic factors in depression among the relatives of a family member who is depressed. Others have studied depression rates of identical twins in comparison to those of non-identical twins. Similar comparisons between biological members and adopted members of families. "Comparisons indicate that genetic components do seem to be associated with manic depressive disorder" (Orbach, 1988, p. 193). Findings on other forms of depression are less conclusive.

"Suicide and depression may be related to low levels of endorphin and serotonin because low pain tolerance and faulty regulation of aggression would cause the individual to be less satisfied, more sensitive, more frustrated, and therefore more vulnerable to suicide" (Orbach, 1988, p.193). This hypothesis is advanced because serotonin is known to regulate the aggression and moods of an individual and

endorphin is a pain reliever released in the brain as one experiences stress or pain.

Salk (1985) and his colleagues investigated biological predisposing factors related to birth. They looked at 1) medical negligence during pregnancy, 2) chronic maternal illness and 3) neonatal respiratory difficulties. 60% of the 52 suicidal adolescents in this study suffered from one or more as compared to only 20% of the controls.

These infants would not have survived without medical and mechanical assistance, and Orbach rather succinctly points out that "children who avoid death with aid of modern medicine may eventually find their way to death through other means" (Orbach, 1988, p. 70).

Three Basic Research Models

Orbach (1988) states that it is possible to identify three causal paradigms underlying nearly all clinical and theoretical material on suicide:

1. The first model postulates that certain life conditions, e.g. divorce, death of a parent, or broken home are the prime reason for suicide.
2. The second model theorizes that suicide is directly related to developmentally accumulating pressures.

3. The third paradigm is considerably more comprehensive and links given circumstances and personality dimensions.

A closer look at the first model that states suicide is caused by adverse life circumstance such as a broken home which perhaps causes feelings of insecurity, abandonment and rejection, which might then lead to depression and suicide. Orbach, states that "the main weakness of such hypotheses is that there is no way of proving that these factors necessarily lead to suicide" (p. 194).

The second model posits that there is a wearing down of coping mechanisms as life pressures impact an individual, and this can lead to strong feelings of hopelessness. Further, when the 'breaking point' is reached suicide results.

(Cohen-Sandler, Berman, and King, 1982) offer an example of this research hypothesis in their study of children who attempted suicide. They determined that the children who attempted suicide in their study were under greater pressure than children presenting with other pathologies.

Personality variables were not considered in this study, and it is evident that individuals handle pressure differently.

The third model postulates that certain combinations of life pressures interacting with personality variables can

result in self destructive behavior. This theory allows for the fact that coping styles vary from person to person; e.g. all young people who lose a parent to death don't attempt nor complete suicide.

Cognitive Theory of Adolescent Suicide

The cognitive theory considers the following:

The Meaning of Death for an adolescent; teenagers often feel a sense of immortality. The often see death as an escape-a peaceful time out and reversible, not final. The youth's perspective on death is limited due to incomplete intellectual development, cultural attitudes toward death, and the media's support of the remoteness of death (Neiger, Hopkins 1988).

Developmental Theory - Eric Erikson

Erikson's stages of development delineate the stage of adolescence as the period in the life cycle when the young person must establish personal identity and avoid the dangers of role diffusion and identity confusion. According to Muus (1988) the adolescent who fails in the search for an identity will experience self-doubt, role diffusion and role confusion, and may indulge in self-destructive behavior. "Ego diffusion and personality confusion, when they became permanent, can be observed in the chronic delinquent and in psychotic personality disorganization" (p. 63). Muus

further relates the increase of suicide among adolescents to a paralleling increase in identity diffusion (Erickson, 1959:132).

Karen Horney

> Insecure children think of the world as a hostile place to live. This causes a basic anxiety. Suicide results from childish dependency and from deep-rooted feelings of inferiority or what Horney calls the "idealized image" one has of him/herself. It may be "performance suicide" springing from a sense of failure in meeting the standards expected by society. To Horney suicide results from a combination of personality and environment (Grollman, 1988, p. 30).

The Expendable Child - Joseph C. Sabbaath

The 'expendable child' theory states that conflictual families often produce children who are made to feel unwanted. Relations between parents are frequently very unstable. This theory further posits that the child becomes a scapegoat for the parents' anger and weaknesses. Sabbath describes the suicidal child as extremely dependent on his parents and feels rejection, abandonment, and worthlessness as a result of the faulty family dynamics. When the situation becomes extreme the child does as he thinks his parents wish and eliminates himself. Life and family situations rather than personality dimensions are the prime motivator for suicide (Orbach, 1988).

This researcher has counseled many seriously suicidal students who made attempts, usually by self-poisoning. There is no doubt that these were 'expendable children.'

One student, for example, was in a foster home because her parents had difficulty controlling her for some time. She wanted to be home with her mother, who was living with the maternal grandmother and a younger sibling. She was last told that she couldn't come home just yet because the apartment was too small to accommodate her.

Another young lady, who is a student in the study, is being shut out by her family because she reported that the landlord had sexually molested her; now the family is rejecting her (albeit not directly) because there is such tension in the home, since the landlord lives in the same house on the first floor.

A third young lady lived with her father and stepmother and was abandoned by her natural mother at age 5 years. She clearly articulated her abandonment issues with her natural mother, and she and stepmother are constantly vying for power in the family. The last serious confrontation they had precipitated the prescription drug overdose. She said to this researcher, "all my stepmother said to me was that I had a nerve to take her pills."

Inheritance of a Pessimistic Attitude Toward Life

This theory holds that certain families suffer from various difficulties and pressures. Their pessimistic outlook on life, fatalistic style of speech, view of death, and submissive attitude are passed on to the children. Either through identification or imitation or the formation of negative expectations of life. In most families of this genre children don't observe positive coping; they surrender and internalize anger. The message becomes life is hard and perhaps it would be preferable to die rather than suffer (Orbach, 1988).

Accumulation of Problems and Ever-Growing Isolation

This model of adolescent suicide is characterized by a gradual decline into total social isolation which eventually leads to suicide. The youth sets out on the suicidal path when life problems are perceived as insoluble. He has no one to share his problems with and believes there is no solution. He sees himself as no longer a member of society and suicide as the only solution (Orbach, 1988).

The Theory of the Unresolvable Problem

This theory embodies the "phenomenological state of mind that reflects the child's experience of being trapped and incapacitated" (Orbach, 1988, p. 196). This model theorizes that young people viewing their set of

circumstances as hopeless with no resolution frequently become depressed and eventually opt for suicide.

It is plausible that this theory explains at least some of the rapidly increasing suicides among young Blacks (males in particular), who can't see a way out of ghetto life with all its attendant problems of drugs, violence, crime, and despair.

This researcher has counseled many incest victims after a suicide attempt. They by far have been the least hopeful group of young people seen at the Crisis Center who appear to be dealing with an 'unresolvable problem,' in that their efforts to deal with their trauma often invites anger and hostility by other family members.

Orbach speaks of the paradoxical facet of the unresolvable problem: "any attempt at resolution generates new problems in its wake. Sometimes, the very act of doing away with a problem becomes a source of difficulty in itself" (p. 202).

This, too, suggests many incest victims. Frequently the abused child finally in desperation turns to a professional or to some other individual who subsequently refers or forces that youth to see a professional; she often experiences the 'paradoxical aspect' of the 'unresolvable problem.' The disclosure of the abuse demands that any mandated reporter in Massachusetts, for example, must file a child abuse report that immediately unleashes the Department

of Social Services on the child and family. In many cases the District Attorney's Office becomes involved. It comes as no surprise that in many cases the child becomes victimized again by the well-intentioned system, and is often ostracized by her angry family or colluding parents for the child's betrayal in telling the 'family secret.' Rarely does the child feel better because she attempted to solve 'the unresolvable problem.' For some such victims, if they weren't suicidal prior to outside intervention, many plunge into the quagmire of suicidal ideation at this point.

No one theory can explain adolescent suicide. A familiarity with various theorists and their views on suicide allow for exploration of this perplexing mental health issue with greater flexibility and open mindedness, and hopefully more creativity for those individual professionals who are clinically working with troubled clients. Educators, too, may benefit from this information. They are in the position to affect constructive changes in the organization, policies, and curriculum of schools where we stand the greatest chance of impacting the young, which will hopefully bring about a decrease in the incidence of suicide, and suicidal behavior.

Adolescent vs Adult Suicide

Following a perusal of the numerous theories of suicide in the adult and adolescent population, it is useful to consider comparisons of adult vs adolescent suicide advanced by experts in the field of suicidology.

David Lester (1988) makes the following observations: Studies of adolescent suicide reveal many similarities when compared to adult suicide such as: severe depression, feelings of hopelessness, social isolation, and viewing death as the only escape from intolerable life situations. However, teenagers, when compared to adults, display more anger at others, and their suicidal actions seem more impulsive (Davis, 1983). Their suicides are more motivated by interpersonal problems and less by intrapsychic problems as they appear to be in adults. (Faberow and Shneidman, 1957).

In a very recent article Lester (1990) notes that:

> Adolescent suicidal behavior does not appear to follow the same sociological pattern as does adult suicidal behavior. Teenagers' rates of attempted suicide, unlike adult rates, appear to be unrelated to the social class of the locale, though both sets of rates were higher in locales where child abuse, neglect and isbehavior were more common (p. 485).

Johnson and Maile (1987, p.70) have listed unique factors when adolescent suicide is compared to adults:

1. often revenge motivated
2. more anger, personal irritation

3. greater impulsivity
4. more negative interpersonal relationships
5. more non-fatal attempts
6. more often families of origin with divorce and suicide
7. less likely to have financial, marital resources
8. more risk-taking behavior
9. more substance abuse
10. more romantic idealism
11. lower self-esteem
12. fewer life-accomplishments to fall back upon

According to the US Department of Health and Human Services (1990) suicide rates for adolescents 15-19 years of age have quadrupled from 2.7 per 100,000 in 1950 to 11.3 in 1988. The following table, Table 1, indicates the statistics on suicide for youth in this country.

Table 1

Suicide Deaths and Rates per 100,000 for the Year 1988 Age: 15-19 Years

Population	Number	Rate
All Races/Both Sexes	2059	11.30
All Races/Males	1668	17.95
All Races/Females	391	4.38
White Males	2145	27.00
White Females	346	4.80
Black Males	136	9.66
Black Females	31	2.24
Other Males	59	16.40
Other Females	14	4.26

*Source: U. S. Department of Health and Human Services

Table 2 is compiled from a 1990 report from the Center for Disease Control which states that "Attempted suicide is a potentially lethal health event, a risk factor for future completed suicide, and a potential indicator of other health problems such as substance abuse, depression, or adjustment and stress reactions."

*Source: U. S. Department of Health and Human Services

Table 2

Suicidal Behavior

. Percentage of high school students reporting suicide ideation and suicidal behavior,* by gender and race/ethnicity – United States, Youth Risk Behavior Survey, 1990†

Category	Suicide ideation		Made specific suicide plans		≥1 Suicide attempt(s)		Suicide attempt requiring medical attention§	
	%	(95% CI¶)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Gender								
Female	33.9	(31.6–36.2)	20.2	(18.5–21.8)	10.3	(9.0–11.6)	2.5	(2.0–2.9)
Male	20.5	(18.2–22.7)	12.3	(10.3–14.3)	6.2	(4.8– 7.5)	1.6	(1.1–2.2)
Race/Ethnicity								
Hispanic	30.4	(27.4–33.3)	19.5	(17.0–22.0)	12.0	(10.3–13.6)	2.4	(1.6–3.1)
White	28.1	(25.6–30.6)	16.1	(14.4–17.7)	7.9	(6.6– 9.2)	2.1	(1.6–2.5)
Black	20.4	(17.1–23.7)	13.5	(10.0–16.9)	6.5	(5.4– 7.7)	1.4	(0.8–2.1)
Total	27.3	(25.2–29.4)	16.3	(14.8–17.8)	8.3	(7.2– 9.4)	2.1	(1.7–2.4)

*During the 12 months preceding the survey.
†Unweighted sample size = 11,631.
§Resulted in an injury or poisoning that had to be treated by a doctor or nurse.
¶Confidence interval.

Psychosocial and Cognitive Aspects of Adolescent Suicide

Social Factors

Family Adjustment

The families of suicidal youth in general show a greater degree of disorganization than the families of non-suicidal youth. Petzel and Riddle (1981) theorize that suicidal behavior in youth may be the result of an "inability to achieve adequate family relationships" (p. 343). A number of family characteristics such as parent loss, conflict in the family, numerous negative parent characteristics, health problems, and poor parenting skills may contribute to the poor familial relationships.

Heilig (1983 p. 4) offers findings of Richman (1971) that outline patterns characteristic of the 'suicidal family system.' Richman studied 100 families that spawned a suicidal adolescent. He hypothesizes that the following "patterns combine to form a unique pattern of family functioning:

1. **Intolerance for separation:** A majority of suicidal families experience more incidents of loss or separation than non-suicidal families. As a result, separation is an overly sensitive issue and a situation is involved often precipitates a suicidal crisis in one of the family members. These families appear to live literally by the motto, "til death do us part."

2. **Symbiosis without empathy:** Suicidal families maintain symbiotic relationships in which the suicidal individual is exploited by other family

members. The needs of the suicidal member are not acknowledged or recognized as other family members are not able to see the suicidal person as separate from themselves. When the needs of the suicidal individual go unheeded, he receives the communication not to be.

3. **Fixation upon infantile patterns:** Suicidal families are threatened by the ideas of growth, maturity, and change since these notions are often equated with loss and separation. Thus, the family encourages fixation on early infantile patterns to prevent growth and subsequent separation.

4. **Fixation upon earlier social roles:** A pattern of role disturbance and role failure is ever present in the areas of social and personal functioning in suicidal families. Suicidal family members, particularly parents, are often playing out social roles which characterized an earlier life period. If circumstances demand that these roles change, the ensuing conflict between new and old roles would precipitate a suicidal crisis in the family.

5. **Closed family system:** Suicidal family has a low tolerance for contacts outside the family system that could threaten to alter the established family structure.

6. **Aggression and death wishes directed against the potentially suicidal person by the family:** In suicidal families, there is a distinct pattern of hostility communicated both verbal and non-verbally to the suicidal individual. The suicidal individual is the recipient of the accumulated aggression of the family.

7. **Scapegoating:** This takes the form of the punitive isolation and alienation of the suicidal person from the rest of the family.

8. **Sadomasochistic relationships:** Members of suicidal families alternate between being hurt and hurting others.

9. **Double-blind relationships:** Members of the suicidal family are characterized by a "barbed wire exterior." Anyone coming close is hurt, yet no one can tolerate distance.

10. **Suicidal person is the "bad object" for the family:** In suicidal families, the suicidal

individual is seen as acting out the forbidden wishes and bad impulses of other family members. The collective guilt over such impulses and wishes is then expiated through the suicidal act.

11. **Quality of family fragility:** A suicidal family regards itself as inadequate to meet the demands of everyday living.

12. **Family depression:** Suicidal families are often preoccupied with death and apprehensive over loss and annihilation of the self.

13. **Communication disturbances:** Suicidal families seem to be unaware or non-receptive to verbal messages from the suicidal family member. In general, the family is characterized by a paucity of dialogue, a tendency towards rejection of mutual communication, and a critical attitude towards establishing communication outside the family system.

14. **Intolerance for crisis:** Suicidal families have no tolerance for a crisis which would affect the everyday pattern of family life.

Parent Loss

The literature review revealed two opposing views on the effects of parental loss. Crook and Raskin (1975) found that in studies with adults who had experienced a childhood characterized by parental discord and the intentional separation of parent and child is associated with attempted suicide in later life, while a childhood characterized by the loss of a parent through natural causes appears unrelated to suicidal behavior.

"Loss of a parent or other loved one probably stimulates suicidal activity in adolescents in different ways, including an effort to copy the parent's example and

self-blame for the loss and desired reunion with the lost one" (Seiden 1969).

Studies in which a positive correlation between parent loss and later development of suicidal behavior reflects a pattern of social upheaval within the family. Loss due to divorce, death, separation, adoption, other appeared to produce no significant difference with regard to the development of suicidal behavior.

Jacobs (1971) found that a greater incidence of parents divorcing, separating and/or remarrying during the onset of adolescence for suicidal youth as compared to nonsuicidal youth. (Petzel & Riddle, 1981)

Hafen (1986) reported that half of all those who successfully complete suicide and 65% of those who attempt suicide come from broken homes. The attempters were predominantly represented in the group whose homes were disrupted by divorce, while the completers were primarily from homes disrupted by the death of a parent.

Family Conflict

Suicidal adolescents are often living in households where a considerable amount of anger, ambivalence, rejection and/or communication difficulties prevail (Petzel & Riddle, 1981). Negative reinforcement and conflict with parents are frequently characteristic of the parent-child relationship

in suicidal girls as compared to nonsuicidal girls (Williams & Lyons, 1976).

"For adolescents a 'poor' relationship with parents has been described as the most frequent reason given for attempted suicide (Senseman, 1969) and family problems appear to be one of the significant stresses occurring at the time of self-poisoning" (McIntire and Angle 1970, 1971a, 1971b) as reported by Petzel & Riddle, 1981 (p. 346).

Jacobs (1971) found that 40% of adolescent suicide attempters had stepparents. "In every case, the stepparent was seen by the adolescent as unwanted" (Petzel & Riddle 1981, p. 347). In a similar study by Teicher (1970) of suicide attempters 84% reported that the stepparent was unwanted.

Parent Characteristics

A number of personality variables and qualities in the parents have been found to be overrepresented in the background of young people who attempt suicide. The health of the parents, both physical and psychological, are particularly noteworthy.

Personality Variables

Absent fathers or fathers with insignificant roles in their lives are common in the background of adolescents who attempt suicide. Hendin (1969) extensively analyzes this aspect of suicide in the Black community, where the lack of a meaningful relationship with a father figure heavily impacts adolescent males, who subsequently become suicidal. (This is explored extensively in the section on Black Suicide). Petzel & Riddle (1981) report that suicidal adolescent youth frequently report that their mothers are rejecting, hostile and domineering, while fathers are frequently alcoholic and noncommunicative (Senseman 1969). Girls attempting suicide frequently report an inability to please their parents or the feeling that they were a burden to their respective families, frequently headed by single mothers. In adolescent suicidal girls, it was frequently determined that the mothers of these girls displayed the following characteristics: "a) depreciation of femininity b) disparagement of men and sexuality, c) expectation of

abandonment by men, and d) covert support for the daughter's promiscuity" (Schrut 1968) as reported in Petzel & Riddle (1981, p. 349).

Studies that used control groups to identify parent characteristics of suicidal teens (Peck & Schrut 1971) revealed parents with the following: in the committed group parents had greater overt striving for success for themselves and their children. Parents of those adolescents in the ideation and attempt groups were more passive while the youths were young. This group of parents showed little response to the successes and failures of their offspring, who eventually used their suicidal behavior to be heard.

As reported by Petzel & Riddle (1981) other studies on the family of teenage girls who had attempted suicide found that these families differed from other families of adolescent girls in crisis (not suicidal) in that they were characterized by less effective productivity, impaired interaction, ineffective communication, and higher rates of negative reinforcement (Williams and Lyons 1976). Additionally, they exhibited less reaction to the crisis (i.e., anger, worry, fear or confusion) involving their child. The adolescents perceived the lack of response as less concern about socially acceptable behaviors (Yusin et. al. 1972). Silence and withdrawal, rather than physical punishment, was the parental response. These caretakers also were less likely to expect obedience, or to desire

better communication with their children. They also were not inclined to seek psychiatric intervention for assistance with the suicidal crisis.

Health and emotional problems

"Approximately 10-15% of parents of suicidal adolescents have suicidal behaviors in their history (Crumley 1979; Margolin & Teicher 1968; Sanborn et. al. 1973; Schrut 1968; Teicher 1970, 1975). About 2% of completed suicides in all persons of all ages and 10% of completed suicides in adolescence have a family history of suicide (Patel 1974). "For the persistently suicidal, 50% of the suicidal teenagers, while only 38% of the suicidal young adults, had a family history of suicide attempts" (Maxmen and Tucker 1973), (Petzel & Riddle, 1981, p. 350). Kreitman et. al. (1969) found that in a study of attempted suicide in social networks (ages 15-65) more younger than older persons who had attempted suicide had positive contact with a significant other who also had attempted suicide.

Petzel & Riddle (1981 p. 351) further report that "Shepherd and Barraclough conclude that the quality of life prior to the parent suicide was important."

Peck and Schrut (1971) found that "whenever a psychiatric or suicidal problem did occur, regardless of which group, the mother was more likely to be identified as experiencing the problem" (Petzel & Riddle, 1981 p. 351).

Other parent problems of attempted suicides in the adolescent population include paternal depression, high use of alcohol or drugs by parents (11-50%: Anastassopoulos and Kokkini 1969; Haider 1968; Jacobs 1971; Senseman 1969; Stanley and Barter 1970; Teicher 1970).

A higher incidence of physical problems were found in parents or other family members of suicidal adolescents as compared to nonsuicidal or successfully suicidal adolescents (Jacobs 1970; Peck and Schrut 1971). Frequent family illness requiring an adolescent to assume a parental role was common to the adolescent suicidal population studied by Teicher (1970).

Parenting style

The significance of parenting style and its impact on impressionable youth cannot be overstated. Hafen (1986 p. 59) put it rather succinctly when he said, ". . . the most important factor in a child's psychological development is the parenting style of the available parent."

Petzel & Riddle (1981) report on the disciplinary approach in the families of a suicidal adolescent; frequently judged by the adolescent to be rejecting and unfair (Jacobs 1971; Lester 1968a; Teicher 1970). The parents on the other hand perceived their disciplinary practices as leading to increased frustration (Jacobs 1971). Teicher (1970) found that suicidal adolescents reported that

their parents nagged, withheld privileges, and used withdrawal as disciplinary practices.

Child Abuse

Deykin et. al. (1985) found that "a social change that has taken place concurrently with the rise in sucide rate among adolescents has been the increase in child abuse and neclect." (p. 1300). Their study in Massachusetts of 159 adolescents who attempted suicide compared the histories of the suicide attempters with a matched group of adolescents and found that the former group was three to six times more likely to have been involved with the Department of Social Services for child abuse.

The authors of this study cite three reasons for a possible line between suicidal behavior and child abuse:

1. Violence is a learned response to frustration and anger.
2. Suicidal individuals and abused children characteristically exhibit low self-esteem. "If low self-esteem is a necessary component of suicidal ideation, persons with low self-esteem, for whatever reason, may be at higher risk for sucidal behavior." (p.1300).
3. If the abuse necessitates removal of the child from the home, this sometimes makes it difficult to maintain meaningful relationships, and

emotional and social disconnectedness may contribute to suicidal behavior.

School Adjustment

The school represents the second most significant social system that the youth is involved in after the family. A good many students experience a great many problems related to school such as school performance, attendance, relationships, behavior, and stress.

Patterns of performance

School performance will describe performance in academics and extra-curricular school-related or sponsored activities. Problems with academics has been the most frequently reported school factor associated with adolescent suicide, according to Petzel & Riddle (1981, p. 353). "Such difficulties have varied from poor and deteriorating performance to underfunctioning and underachievement" (Connell 1972; Finch and Poznanski 1971; Sabbath 1971; Sanborn et. al. 1973; Schrut 1968; Senseman 1969).

Patterns of attendance

Petzel & Riddle report that Teicher (1970) discovered that as much as 36% of adolescents who attempted suicide may not have been enrolled in school at the time they made the attempt, and adolescents with chronic school problems may

have dropped out of school by the time of their suicide attempt (Barter et. al. 1968). Marks and Haller (1977) discovered that suicidal adolescent girls are reported to drop out of school more frequently than suicidal boys, and as other emotionally disturbed girls.

Research indicates that poor scholastic achievement is not the reason that adolescents do not attend school. Teicher (1970) reported that reasons other than scholastic performance and which were directly related to the attempt accounted for nonattendance in 89% of the cases in his study. Behavioral problems, illness, prior suicide attempts, and pregnancy were some of the reasons listed.

Pregnancy is a major issue. Nearly a million teenagers run away from home each year in this country. Girls account for almost half this number; as many as 40% of them do so because they are pregnant. When interviewed later, they make statements such as "My father said that if I ever became pregnant he'd kill me," or "My mother said that if I ever became pregnant I shouldn't come home" (Gordon & Gordon 1983 p. 104). These runaways face horrors that are simply beyond belief. A number of these girls become the victims of pimps who force them into prostitution. It may also be appropriate to add that pregnancy is reliably reported to be a major reason for suicide among teenage girls, according to Gordon.

This researcher's experience, as well as the experience of other professionals working with Cape Verdean immigrant females suggest that pregnancy is a major reason for suicidal behavior in this ethnic group and will be explored further in Chapters IV and V.

Jacobs (1971; Lukianowicz 1968) as reported by Petzel and Riddle (1981) found that suicidal adolescents attend a large number of different schools; some had changed schools frequently in the five years preceding the attempt. American families are very mobile and change residences often; this is responsible for creating in youth an additional sense of loss-the loss of familiar surroundings, old friends and schools.

The effects of mobility, according to Barret (1985) were studied by Headington, who believes that the formation of strong attachments to teachers, peers, and others is a critical part of the identity process of adolescence. Mobility disrupts the formation of such attachments, often leading to increased vulnerability to feelings of loss, sadness, and grief" (Barrett 1985, p. 24).

Patterns of relationships

School records of suicidal adolescents indicate that they experience at greater frequency clashes with other students, conflict with teachers, and have a lack of friends at school.

Petzel & Riddle (1981 p. 356) report that

> Conflicting results indicate that male adolescents attempting and threatening suicide, compared with other emotionally disturbed adolescent males, have fewer problems with relationships at school and that teachers were influential to them. At the same time, suicidal adolescent girls, in contrast with other emotionally disturbed girls, were less likely to have a favorable attitude toward teachers (Marks and Haller 1977).

Married teens constitute a small percentage of the adolescent population, but they are more vulnerable to suicide than the general teen population. Hawton (1986) reports that in the 15-19 year old male population, married teens are 1.5 times more likely to commit suicide than the unmarried. Married girls in this same age group are 1.7 times more likely to commit suicide than the single girls. Studies (Bancroft et. al. 1975; Kreitman & Schreiber, 1979) suggest that teenage wives in particular appear to have fled unhappy families only to end up in disastrous marriages.

Patterns of school behavior, attitudes, and stress

Findings of Marks, Haller, Barter were reported by Petzel & Riddle (1981): Disciplinary and behavior problems, lack of interest, dislike of school, boredom and fear are some of the reported school difficulties of suicidal adolescents. Labeling a student a failure when he is having school difficulties also may be a stressor contributing to suicidal behavior (Sartore 1976). Marks and Haller (1977) reported that suicidal adolescent girls had more behavior

problems in school than suicidal boys or other emotionally disturbed girls, and were also more likely to have poorer grades, more attendance problems and more disciplinary situations than the suicidal boys and other emotionally disturbed girls (Barter et. al. 1968). Adolescents who committed suicide also experienced stress as a result of attendance at competitive schools and parents' high expectations and criticism regarding school.

Hafen (1986) reported that psychotherapist Margery Fridstein, whose practice is on Chicago's North Shore, said that many of the parents of that area put pressure on their children to either reproduce what they themselves have accomplished or achieve better. The number of stress related suicides arising from this situation is the reason why the area is dubbed the nation's 'suicide belt.'

Among college students the pressure to achieve and maintain is responsible for student suicides; anxiety over work, especially examinations is one of the most common precipitating causes of the preoccupation with suicide.

Social Relationships

Loss

Suicide is frequently precipitated by loss or threatened loss of a boyfriend, girl friend, or parent; intense reactions to loss are also common precipitants of suicidal behavior in adolescents.

Much research has been done on the effect of parental loss on adolescent suicide. Klagsbrun (1976) postulates that a child suffers a great deal from the actual loss of a parent.

> Some studies have shown that if a child is not helped to handle the despair of losing a parent during the early years of life that child may suffer severe depression and suicidal thoughts in later years. A child whose parent dies experiences what Robert Jay Lifton calls 'survivor guilt.' The child wonders why he or she remained alive while the parent died. Sometimes the child becomes angry at the parent who has abandoned the family so abruptly and then terrified and guilty at having such feelings directs the anger inward (p. 43).

Klagsburn further states that during adolescence, when the child is going through physical and emotional changes, the complex feelings of loss experienced in childhood may erupt, ultimately causing the adolescent to become suicidal.

Hendin (1982 p. 40) reports that "the Harvard study of student suicide discovered a statistically significant correlation between suicide and the death of a parent." Gregory Zilboorg reported on the greater incidence of parental loss through death in the history of suicidal adolescents. Hendin reports on Zilboorg's theory on loss and suicidal behavior in adolescents. Zilboorg posits that when a boy or girl loses a parent or sibling at the height of the Oedipal complex, or the transition to puberty, there is a danger of suicide.

Becker (1973) in The Denial of Death postulates that children, when frustrated by their parents, direct hate and destructive feelings toward them, and they have no way of knowing that their malevolent wishes do not have magic and cannot be fulfilled as were other childhood wishes (more than likely fulfilled by parents). "Psychoanalysts believe that this confusion is a main cause of guilt and helplessness in the child" (p.18). Sanford (1990) in Strong in the Broken Places highlights the case of Joan, who lost her mother at age ten. The day before her mother died, Joan and her mother were upset with one another due to Joan's lack of assistance in the house. Although she really loved her mother very much, she experienced childhood anger and secretly wished her mother "to drop dead and leave her alone." The next day the mother was whisked off to the hospital and died, before Joan who felt very guilty, had an opportunity to say goodbye or I'm sorry. The subsequent guilt erupted in suicidal behavior in adolescence.

Hendin (1982) speaks to this issue in stating that what is really critical for children regarding the loss of a parent through death is the nature of the relationship with the parents prior to the loss, which clearly underscores Joan's pain (Strong in the Broken Places).

Interpersonal conflict, frequently precipitates suicidal behavior in adolescents. Petzel & Riddle report the findings of Crumley and Yusin: Suicidal adolescents are

commonly found to display a pattern of unstable and intense interpersonal relationships and also have difficulty being alone (Crumley 1979). Yusin et. al (1972), compared suicide attempters with adolescents displaying other forms of crisis behavior. He found the attempters to be considerably more unhappy. They appeared to want human relationships, yet seemed unable to maintain them.

Hendin (1982 p. 46) theorizes that "the life-or-death meaning that suicidal young people give their relationships derives from their need to recapitulate and relive the intense unhappiness they have known with their parents." He further states that young woman make suicidal attempts much more frequently over a broken relationship than do young men. Hendin adds that the attempts are usually not serious, but are designed to revive a failing relationship.

This researcher's experience with teens bears out Hendin's findings on relationships and suicidal behavior. We have young people in intimate relationships that they cannot handle emotionally. It is especially devastating when the relationship ends. The rejected lover scenario suggests that all teenagers, like most everyone else, want to be loved and connected to significant others. Sometimes this is impossible in dysfunctional families and teens feel an incredible void. To compensate for this lack, they may seek this love and feeling of belonging in relationships with peers of the same sex as well as opposite sex peers.

For this reason the breakup of a relationship is often so devastating that it precipitates a suicide attempt. In this researcher's experience with high school students, the breakup of a relationship has been the most common antecedent of suicidal behavior. When the boyfriend or girlfriend says goodbye, they are frequently cutting off the only source of love, affection, and understanding that a young person has, and this is often too much to bear. Usually, as Hendin states, the victim is female. However, on Friday, October 26, 1990, a young man who had attempted suicide the day before by taking a drug overdose was referred to the Crisis Center. His story of maternal rejection, emotional abuse, and the lack of a father figure for many years, revealed how pained he was and how important the girlfriend who had just broken up with him was. Her loss was more than he could handle in his world of emptiness.

Suicide pact

Another aspect of adolescent suicide and relationships is the **love pact suicide** or **suicide pact.** The love pact suicide, which is much more prevalent in elderly couples with one or both partners suffering from illness, has become a youth problem as well. Hendin (1982) states that love pact suicides have been romanticized more than any other form of suicide; he further adds that some believe that

pacts are to preserve love. From his experience, however, he states that a few young people who survived such love pacts suggest that external difficulties, such as parental opposition to the relationship, are the least of the couple's problems. "Rather their own personal problems usually prevent them from having a satisfying relationship. The man is likely to be the instigator in such pacts, and sometimes the woman is a very reluctant participant" (p. 221). Hendin saw the love pact as a form of tyranny, rather than a covenant to affirm and immortalize love.

Suicide pacts are not always an agreement between lovers. Sometimes the agreement to jointly end life is between friends. In October of 1984 a gruesome suicide pact was executed in Leominster, Mass. Two 15 year old girls shot themselves in the head with a 12 guage shotgun in one of the girls bedroom. In South Bergen, New Jersey in 1986, four adolescents entered into a suicide pact and killed themselves by carbon monoxide poisoning in a car in one of the youths garage.

Social involvement

Adolescents in suicidal crisis are often described as socially isolated, withdrawn, alienated, lonely, and rejected. Petzel & Riddle report the following: Loneliness in many cases has contributed to the suicidal behavior in older adolescents (Ropschitz and Ovenstone 1968). For some

adolescents, increasing withdrawal and asocial behavior occur just prior to the attempt, while in other cases of suicidal adolescents, their antisocial behavior has been long standing (Jacobs 1971; Lukianowicz 1968; Schrut 1968).

In an effort to better understand the social relationships of suicidal youth, studies including control groups have been implemented. Peck and Schrut (1971) as reported in Petzel & Riddle (1981 p. 357) compared college students committing, attempting and threatening suicide with nonsuicidal students. "Sixty-one percent of the suicidal, compared with 31 percent of the nonsuicidal students 'spent considerable spare time in solitary activities' before high school. Nonsuicidal students dated more frequently in high school and college than suicidal. Those students who committed suicide were more isolated and less likely to send out communication signals for help."

Marks and Haller (1977) discovered that suicidal females appeared to be more socially isolated than males. The results of their studies indicated that adolescent males who attempted suicide, in comparison to other emotionally disturbed male adolescents, spent more time with older girls and less with males of similar age during childhood. They continued to lack close relationships with males in adolescence. The suicidal females studied by Marks and Haller in comparison to other emotionally disturbed girls, had few if any friends during childhood, and during

adolescence they had no one with whom they could discuss personal problems, and did not appear to value friendships.

Cantor (1976) reported that female suicide attempters who ranged in age from 18 to 25 had high affiliative, succorant, and nurturant needs. "More specifically, high succorant needs, interacting with an inability to reach significant others, distinguished young women who attempted suicide from those who frequently thought about suicide" (Petzel & Riddle p. 358).

Klagsbrun (1976) stated that children who grow up feeling unloved become deadened and morose adolescents. These young people turn against themselves and others. They frequently retreat into a fantasy world, isolating themselves from the real world; they become loners incapable of giving or receiving love. In some cases, they become seriously depressed and suicidal.

Sexual adjustment

Senseman (1969) found that guilt over sexual activity was frequently reported as the reason for suicide threats or attempts, according to Petzel & Riddle (1981).

Roberts and Hooper (1969) "identified six life styles characteristic of suicide attempters of all ages. One of these, the 'sexualized style, includes many of the sexual characteristics noted in case studies of suicidal

adolescents and is characterized by promiscuity, multiple, premature, or precipitous marriage, and homosexuality" (Petzel & Riddle, 1981, p. 359).

Incest victims are frequently suicidal during adolescence. Each and every one of the young ladies who were incest victims and counseled at the high school for suicidal behavior had no self-esteem and spoke quite freely and emphatically about being worthless and loved by no one.

Religious involvement

According to Petzel & Riddle (1981) no significant relationship between religious affiliation or belief in an afterlife and attempted, threatened and committed suicide has been established through research. Peck & Schrut (1971) found that adolescent girls attempting suicide, in comparison to other emotionally disturbed girls rarely attended church (Marks and Haller 1977), and adolescent girls committing suicide believed in an afterlife more often than other suicidal groups (Peck & Schrut 1971). McIntire and Angle (1971b) reported an increase in self-poisoning in a population of older adolescent Jewish males.

A number of reports suggest that a relatively high percentage (20-22) of people in all age groups, including adolescents, attempting/threatening suicide are Catholic.

Gabrielson, Klerman, Currie, Tyler, and Jekel (1970) studied a population of pregnant women (17-25 years of age)

who were single, Catholic, middle income level and above who attempted/threatened suicide. They were compared to nonsuicidal women who also had borne children while teenagers. The results of the study indicated that a higher percentage of the Catholic, middle income women attempted/threatened suicide. The implications of the study were that acceptability or relative lack of acceptability of one's social group might be a contributing factor, particularly in consideration of the attitudes of the Catholic church. In light of demographic information from Catholic and Protestant countries suggesting that the suicide rates among Catholics would be lower, these findings are most interesting.

Sorenson and Golding (1988, p. 326) reported the following conflicting information: "Religious commitment and Catholicism have been associated with reduced suicide rates" (Durkheim, 1897/1951; Maris, 1981). They concluded that "non-Catholics were significantly more likely to report sucide ideation than Catholics among the non-Hispanic Whites." (p. 328).

It would appear that the issue of religion and its correlation with adolescent suicide would be more complicated than just a breakdown of denominations. Petzel and Riddle suggest that factors such as strength of religious conviction might be a factor. This researcher believes that frequency of church attendance of both

adolescents and their parents, as well as their strength of religious conviction would also be relevant. Religion was considered by many Cape Verdean professionals to be a deterrent to suicide.

Situational Factors

Domestic and Financial Situation

Residential mobility appears to be associated with increased rates of attempted and completed suicide among adolescents.

Bakwin (1957; Finch and Poznanski 1971) suggested a higher rate of suicidal behavior for urban dwellers. "Poor housing as a factor among Black suicide attempters who were young but not solely adolescents (mean age 20.2), and medium to-low family income (Jacobziner 1960; Teicher 1970) among urban adolescent suicide attempters have been reported. Unemployment and/or debt (Bagley and Greer 1972; Seiden 1969; Smith and Davison 1971) particularly among youthful males, and overcrowded living conditions as factors in youthful suicide also have been described (Petzel & Riddle, 1981 p. 361).

Petzel & Riddle (1981, p. 361) offer the following: Seiden (1969) reports that during periods of economic depression, adolescent suicide increases, as does adult suicide. This is challenged, however, by Yacoubian and

Lourie (1969) who maintain that high suicide rates observed during depressions do not apply to adolescents.

Gabrielson et. al. (1970) report that there is a higher proportion of pregnant adolescent attempters who come from families of nonpoverty, rather than poverty, level income.

Hendin (1969) posits that the rural suicide rate in the U.S. is now as high as the urban rates, and suicide is highest among the lowest social classes.

Rural America is experiencing the pains of poverty as farmers are losing their farms and lifestyles. For many of the landowners, their farms and chosen occupation had been in the family for generations.

"There has been a marked increase of suicide among farmers in the U.S. With the loss of their farms there ensues a weakened family structure as the household is forced to create a whole new way of life" (Grollman 1988, p. 36).

A significant aspect of rural life is loneliness. The adolescent without a close confidant and unable to deal with the loneliness is at risk for suicide (Forrest, 1988).

It appears that financial status alone does not determine suicide in the adolescent population. Financial status may be a contributing factor, but clearly other factors, such as living conditions, gender, family circumstances, etc., interacting with financial conditions predispose one to suicide.

Climatic Influences

Spring is reported to be the most common time for attempted or completed suicide to occur, with May being the peak month. This is true for adolescents as well as adults, according to Petzel & Riddle (1981).

Media Influence

The media effect on suicide dates back to 1774 when Johann Wolfgang von Goethe published the romantic novel, The Sorrows of Young Werther. The artistic Werther, "who loses himself in fantastic dreams and undermines himself with speculative thoughts until finally, torn by hopeless passions, especially by infinite love, shoots himself in the head" (Grollman 1988, p. 56) This book was blamed for the suicides of young men all over Europe, and was eventually banned. The term **'Werther effect'** was originated to designate the imitative influence on suicide. **Cluster suicides** or **copycat suicides**, which are primarily a youth phenomenon, are other terms used to describe suicides that are precipitated by another's suicide. Frequently the initial suicide is learned of via the media or it is a suicide of someone known to the victim(s). In Houston, Texas in 1984, 5 teenagers separately committed suicide in a six week period. Eleven students living in the comfortable suburban community of Plano, Texas killed themselves during a 20 month period in 1984. Hendin (1981) reports that

independent studies done by the psychiatrist Jerome Motto and the sociologist David Phillips give evidence that sensational press coverage of suicide and tragic deaths causes an increase in suicide immediately afterward.

The music of our youth with its suggestive lyrics has also come under attack and suspicion of precipitating the suicides of a number of impressionable youth. **Ozzie Osborne**, British rock star, is being sued in the Georgia courts (Entertainment Tonight, October 10, 1990). The parents of Tommy Waller claim that Osborne's record **'Suicide Solution'** with subliminal messages and overt references (e.g. 'why try, get the gun and try, get the gun and try, shoot, shoot, shoot) precipitated his suicide. How tragic indeed, if our most vulnerable youth, seeking relief from life's stresses in their music, find instead a vehicle to hasten their demise.

Availability of Means

Studies on the incidence of adolescent suicide suggest that there is an increase coinciding with the availability of specific, potentially lethal, prescription medications and with readily available handguns. Browning (1974) reported that three of four teenage suicides in his study used handguns. Vidal (1989) reported that 62% of teens who commit suicide kill themselves with a gun. In a recent Time magazine article, Gibbs (10/8/90) reported that every 36

minutes a child is killed or injured by a gun, and every day 135,000 children bring their guns to school.

Clarke & Lester (1989) examined the relationship between gun availability and the suicide rates in the 48 continental states for the year 1970. **The Vital Statistics of the United States, 1970** was used to obtain the suicide rates by gun, by all other means and overall for each of the states, the proportion of homicides by guns, and the accidental death rate from guns. The results indicated that the less available guns were in a state, the lower the suicide rate by guns was. It is most interesting that the reduced availability of guns correlated positively with higher rates of suicide by all other methods. This raises the possibility that there is some switching, or displacement, between methods, depending on firearms availability.

Hendin (1982) states that evidence indicates that suicide rates are not a function of the availability of a particular method, since the suicide rate is no higher today than it was at the turn of the century, yet the incidence of suicide by firearms is twice the rate it was at that time.

Hendin and others who concur with this view may be right insofar as the overall suicide rate is concerned; however, this researcher believes that decreasing the availability of firearms would have a dramatic effect on the

rate of adolescent suicide by firearms, the most common method of this age group.

Hawton (1986 p. 132) cites Eisenberg (1980) who noted: "1) many suicidal acts are impulsive and rely on immediate availability of a method; 2) even in those with serious suicidal intent, one method may be acceptable while others are not; and 3) many young suicide attempters are highly ambivalent about going through with an attempt."

On March 6, 1985, the city of New Bedford was horrified when Bruce Perry, a 16 year old junior at Greater New Bedford Regional Vocational-Technical High School, shot himself in the head in his Geometry class in the presence of his teacher and classmates. He died two days later, and the entire city mourned his loss and felt quite acutely the pain of the adolescent suicide crisis that is overwhelming this nation (White, 1985).

It is this writer's opinion that gun control legislation would have a dramatic effect on the Black community where Hendin (1982) states the homicide rate is ten times higher than among any other group in the United States, and he highlights the fact that as a group individuals who kill themselves have committed homicide at a much higher rate than the general population, and individuals who have killed others have a much higher suicide rate than has the overall population.

The following statement by Hendin (1982) is extremely interesting: "While suicide among young Blacks has been obscured or ignored, the high frequency of homicide by Blacks has not been similarly neglected." Black homicide reaches a peak at the same time that Black suicide does (20-35 age period). This fact will be further discussed in the study of Black suicide.

Availability of Mental Health Resources

Suicide prevention for the general population has experienced tremendous growth in recent years. However, there is much criticism that this proliferation of help has not had a significant impact on overall suicide rates. According to Klagsburn (1976) the effect specifically on the adolescent suicide rate is unclear, and critics feel that these efforts do not reach the most seriously suicidal individuals.

Studies with adolescents in Indian and Eskimo boarding schools indicate that increased emotional help offered by social workers in the dormitories reduced the incidence of suicide attempts in these populations (Harvey Gazay, and Samuels 1976).

Cognitive Functioning

According to Petzel & Riddle (1981) studies with adults (Yufit, Benzies, Fonte, and Fawcett 1970) in addition to

studies with adolescents exclusively (Melges and Weisz 1971) suggest that individuals with suicidal ideation have a limited focus on the future and a less elaborate concept of future time. Adolescents seeking to escape future expectations that are somewhat negatively distorted frequently become suicide attempters (Hynes 1976). Problem solving capability in suicidal adolescents appears to be impaired (Levenson and Neuringer 1971), and suicide is frequently the only option available while under stress (Maxmen and Tucker 1973). Petzel & Riddle (1981) report that overall intellectual functioning for suicidal adolescents appear to be average to high average (Dudley, Mason, and Rhoton 1973; Maxmen and Tucker 1973), with superior abilities second and a retarded level of intellectual functioning uncommon (Senseman 1969).

Concept of Death

Adolescents' concept of death suggests that many young people in this developmental stage do not appreciate the finality of death. Death is viewed as an escape from an intolerable situation, a time-out.

Klagsbrun (1976 p. 47) offers the following: "Many teenagers and young adults-well into their twenties-have an unrealistic view of death. In their minds' eye they see themselves as wrapped in a cloak of immortality. Even those

who attempt suicide usually lack a true concept of the finality of death."

Klagsbrun also stated that young people see their death as a way to punish someone who has wronged them (parent, boyfriend, etc.), and somewhere in their mind's eye they believe that they will be present to experience the benefit from the punishment that their death has inflicted or the love that it has aroused.

Hopelessness and Helplessness

Studies clearly link suicidal behavior and a negative outlook. Melges and Weisz (1971) according to Petzel & Riddle (1981) report that suicidal ideation was correlated with a sense of hopelessness and a feeling of little personal control over one's life circumstances (helplessness). Additional studies correlate negative expectations or hopelessness and seriousness of intent of suicide attempters. Seriousness of intent appears to be very closely related to hopelessness than to the syndrome of depression in general (Minkoff, Bergman, Beck, and Beck 1973).

Hawton (1986) reported that a sense of hopelessness, rather than general depression is a major determinant in suicidal behavior. According to Hawton, Kazden and his colleagues (1983) demonstrated this phenomenon in a sample of children age 8-13 years.

Grollman (1988 p. 40) also emphasizes the role that hopelessness and helplessness play in youth suicide. "While there is no single reason why a teenager will take his or her own life a leading factor of adolescent suicide is a pervading sense of hopelessness and helplessness."

Individual Characteristics

According to Petzel & Riddle, "identification of individual characteristics of suicidal adolescents - what loosely might be defined as personality characteristics - have included dimensions of emotional adjustment, self-concept, and motivation" (1981, p. 368).

Emotional Adjustment

The presence of a number of problems in adolescents can be indicative of emotional difficulties leading to suicidal behavior: behavior problems, drug and alcohol abuse, affective disorders, etc.

Behavior problems

Jacobs (1971) as reported in Petzel & Riddle (1981) found that suicidal adolescents had a long history of behavior problems and that it was common for these problems to escalate in the weeks and months preceding the suicide attempt.

Alcohol/Drug use

A number of studies have focused on the frequency of suicide attempts in a population of adolescents who use drugs. This group appears to be highly vulnerable to suicide. Frederick et al. (1973) discovered a higher rate of previous suicide attempts reported by youthful heroin addicts in comparison to delinquent and normal controls. "Twenty-one percent of addicts and 8 percent of controls reported attempting suicide at some time in the past" (Petzel & Riddle 1981, p. 371). Hassal (1969) found an even higher number of suicide attempts among young (under thirty) male alcoholics. "Forty-five percent reported having attempted suicide at some time in their lives, while 80% reported suicidal thoughts or impulses" (Petzel & Riddle 1981, p. 371). There are a number of studies suggesting that adolescents seriously addicted to drugs are far more likely to attempt suicide than adolescents who are not addicted.

Grollman (1988) reports that among alcoholics in general the risk for suicide is 20-30 percent; among adolescent alcoholics the rate may be as high as 50%. Other researchers have placed the risk for suicide in the alcoholic youth population as high as 80%. Prolonged drinking according to Grollman induces progressive depression, guilt, and psychic pain, which commonly precede suicide. This becomes especially ominous when the

statistics on alcohol and drug use in this country's adolescent population are considered. Vidal (1989) reported that a 1987 public television production entitled 'Generation at Risk' offered these facts: approximately 9,000 teens are killed yearly in motor vehicle accidents, which is the leading cause of death of teens; 52% of the fatally injured teen drivers tested had alcohol in their blood; it was estimated that 3,538 teens died in alcohol related accidents (some of which were questionable suicides). 92% of the seniors in the class of '86 reported that they used alcohol; one in twenty seniors used alcohol or marijuana daily. The U.S. Public Health Service survey concluded that 15% of 8th graders had used marijuana; 1/3 of high school sophomores had tried drugs; 80% of eighth graders and 90% of tenth graders had consumed alcohol in the past month.

One of this researcher's first seriously suicidal students was Gary, a senior, who was a cocaine addicted youth. His escalating habit had frightened him considerably. One morning in a very desperate state, he came to the Crisis Center. He referred himself as a last resort. He stated that he had been sleeping with a gun under his pillow because he couldn't continue living the kind of life that a serious cocaine habit demanded; stealing, doing coke, fighting with his parents (who claimed they had no idea that he was in such deep trouble) and

trying to continue in school. He said if he couldn't get help at the center, he didn't know where else he could go. Gary was admitted to a hospital in Worcester that had an adolescent unit. He probably would have been a completed suicide, not an uncommon end for drug addicted adolescents, had he not been hospitalized. Miraculously, Gary, a very bright student managed to graduate at the end of the summer school term.

Mood disturbance

According to Petzel & Riddle (1981) depression is the most frequently reported affective component for suicidal adolescents; however, anger and rage (McIntire and Angle 1971b) and irritability (Lester 1968b) have also been described as characteristic of suicidal youth. Depression in suicidal adolescents is far less common than depression in suicidal adults (Balser and Masterson 1959; Seiden 1969). Older teens often show the classic symptoms of depression typical of adults, while younger adolescents manifest depression quite differently. 'Masked depression' which is characterized by serious acting out, impulsivity and impatience, is not uncommon in troubled teens. According to Petzel & Riddle (1981 p. 372) "quantitative estimates of the prevalence of depression reported for suicidal adolescents range from 40% (Mattsson et. al. 1969) to 80% (Crumley 1979; Marks and Haller 1977), while estimates for control groups

of disturbed, nonsuicidal adolescents range from 13% (Mattsson et. al. 1969) to 46%" (Marks and Haller 1977).

Depression in suicidal adolescents frequently lifts just before the attempt (Seiden 1969). It is theorized that there might be a sense of relief brought about by having made the decision to end one's life.

Self-Concept

According to Petzel and Riddle (1981 p. 380) "feelings of low self-esteem have been attributed to youthful suicide attempters in studies by Senseman (1969) and Toolan (1962). However, in neither study were control groups used nor was there an attempt made to rule out the effects of youth or general emotional disturbance upon self-concept. According to Senseman (1969), suicidal youths expressed their low self-image with words such as 'unloved, alone, inadequate, failure, inferior, unworthy, unattractive, difficult, no good, bad, a nobody, nothing but a burden' and many other negative descriptions." Low self-esteem was sited frequently as a contributing factor in youth suicide by theorists and practioners.

Physical Illness

Physical illness in some adolescents has contributed to suicidal behavior. Depending on the nature of the illness, it can distort self-concept or contribute to a depressive

emotional state. Adolescents want to feel that they are just like their peers; they do not want to be set apart, and illness, physical abnormalities, or any disfigurements can cause depression and possible suicidal behavior.

Deykin et al (1986) states that "the unusually high frequency of suicidal adolescents with preexisting chronic or handicapping conditions suggests that poor health, especially that which limits mobility or compromises normal physical development, may be an important, but unrecognized, risk factor for suicidal behavior in adolescence" (p. 94).

Klagsbrun (1976 p. 45) offers the following: "Another kind of loss, a sad, unrelenting loss, also can lead to serious depression and suicidal thoughts among the young. That is the loss of physical health, and with it, the view of oneself as a complete and wholesome person."

According to Petzel & Riddle (1981) Marks & Haller (1977) found that suicidal adolescent males manifested gastrointestinal and nervous system somatic involvement and sometimes were physically handicapped. They reported physical illness as a correlate of suicidal behavior in adolescent males, but not females. Weinberg (1970) found that physical illness seemed to influence suicidal ideation in adolescent boys if it presented as an obstacle to achieving competencies related to the masculine identity. Adolescents girls were reported to tolerate physical illness

to the extent that it elicited care and nurturance; however, suicidal ideation was problematic with adolescent girls when it was perceived as the cause of rejection.

This researcher experienced several students whose illnesses and incapacitations ultimately necessitated a referral for suicidal behavior. For seniors, the senior prom is one of the highlights of this final year in high school. Mary was wheelchair bound as a result of the 4th level of spina bifida. By the time Mary had been referred, she had had so many operations on her back that she had lost count. Things were fine and Mary seemed to take life in stride, until late adolescence, when she began to notice boys. Her frustration and anger peaked during senior year when it was time to secure a prom date. She asked a young man who accepted in February, but as Spring drew near he decided he 'just couldn't go.' Mary was devastated, to say the least, and this was the beginning of her escalating feelings of hopelessness and helplessness. The fact that her brother offered to take her was not an answer. The family, although very supportive of Mary, needed lots of help in trying to get in touch with the adolescent world and why this was so painful to their loved one.

Another very sad case was Sarah who had a severe heart condition that drastically curtailed her physical activities. She was often sad and frustrated, and she felt that people were laughing at her. Sarah, in actuality was

loved by all, but it was her perception of her world that mattered, and it was this perception that fueled her depression. It was a very sad day when this researcher attended her funeral following her death due to heart failure. While paying final respects to this lovely child, this researcher couldn't help but remember the many occasions when she stated that she was so unhappy that she wanted to die.

Intent and Motivation

The identification of self-destructive behavior as suicidal is extremely complex. It often becomes a matter of interpretation.

According to Petzel & Riddle (1981 p. 381) "self-destructive behavior simplistically represents a behavioral continuum ranging from destructive behavior without intent to die to destructive behavior with intent to die." The matter is further complicated, especially with adolescents because it can be difficult to distinguish accidents from suicides such as the 'autocides' that always lead to conjecture about intent. Many completed suicides are miscalculations that were the results of misguided 'cries for help' that went awry, and that had not been intended by the victim to end in death. On the other hand, Many foiled attempts were miracles since in 99% of the cases, death

would have been the final outcome, but fate intervened (e.g. jumping from the Golden Gate Bridge).

A more in-depth look at the distinction made between attempted and completed suicide is warranted. Suicidologists differ in their opinions on the subject. Some believe that there is a distinct difference between the population that attempts and the population that completes suicide. Others in the field view the two populations as overlapping, and this researcher concurs with the latter opinion.

According to Grollman (1988) 12% of individuals who attempt suicide will make a second attempt within two years. Four out of five of those persons who complete suicide attempted to so at least once previously.

Hawton (1986) cites Shaffer (1974) who found that 46% of adolescent suicides had previously discussed, threatened or attempted suicide. Eight of these young people did so within 24 hours of their death. This particular study unfortunately did not distinguish between attempted, threatened, or discussed; however, (Shaffer and Fisher 1981) in a later report indicated that 40% of those studied had attempted previously. Similar findings were reported by Cosand and Associates (1982). They also discovered previous attempts were more common among females than males, and they theorized that this was so because of the higher incidence

of attempted suicide in the female population and because males tend to use more lethal methods.

Klagsbrun (1976 p. 26) states that

> For all the differences, parents, friends, and even professionals who overemphasize distinctions between the motives of young suicide attempters and those who complete suicide play a dangerous game. Often only a thin line separates the two, and many an attempter who may have 'just wanted attention' ends as a grim statistic. In too many cases fate or chance rather than intention determines who will live and who will die. Sometimes persons bent on self-destruction, who use the most lethal methods possible, survive almost miraculously. . . . others who seemed less determined to die, did so almost accidentally.

In some instances the death wish is unconscious and in the majority of cases there is considerable **ambivalence**. Hendin (1982 p. 210) states that "Studies of those who have survived serious suicide attempts have revealed that a fantasy of being rescued is frequently present." Hendin discussed four of his cases that involved individuals who had survived six story suicide jumps. Two of the surviving individuals reported to Hendin that they wanted to survive as soon as they had jumped, two said that they did not, but the two who said that they were furious at surviving did not make any subsequent suicide attempts. Hendin further emphasizes that if for no other reason than the persuasive evidence of ambivalence surrounding suicide, some intervention is warranted. Hawton (1986) further states that even with the use of a gun, which may appear to imply very serious suicidal intent, ambivalence is common.

Of youth in particular, Patros & Shampoo (1989 p. 52) suggest that "There is an ambivalence about dying in most, if not all, children and adolescents. They want to live but living is too painful. Most suicides occur in the home and at a time when intervention might be possible. Frequently, there are calls for help immediately following a suicide attempt. This reaching for help is indicative of the ambivalence about dying."

Racial/Cultural Variables

Racial or ethnic differences and cultural changes can be sources of vulnerability. This researcher is extremely interested in this aspect of suicidal behavior, particularly in youth of color and researched this mental health issue in a number of minority groups, as well as immigrant populations. The investigation revealed that there is a paucity of research on minority youth suicide, and studies are definitely needed to remedy this tremendous lack.

Black Suicide

Suicide in the Black community is a youth problem and a very serious problem that is often obscured by the statistics on suicide in general. The very high frequency of suicide among older White males in the U.S. causes the overall percentage of Black suicide, to be lower. This

overshadows the ominous truth about adolescent suicide amongst Blacks which is extremely high.

According to Gibbs (1988, in Maris, ed., p. 73) suicide is the third leading cause of death of Black youths age 15-24. It is exceeded only by accidents and homicides. "47% of all Black suicides occur in the 20-34 age group" (U.S. Bureau of the Census, 1986).

Gibbs highlights the fact that a review of the literature on Black youth suicide provides limited conceptual approaches, a minimum of clinical investigations, and a paucity of empirical studies.

From 1960-1983 the suicide rate for Black youths aged 15-24 doubled for Black females (from 1.3 to 2.7 per 100,000) and nearly tripled for Black males (from 4.1 to 11.5 per 100,000). This trend is nearly identical to White suicide rates. Klagsbrun (1976) states that in New York City young Black males commit suicide twice as frequently as young Whites. This trend is beginning to appear in other large urban areas as well.

Gibbs delineates 3 conceptual perspectives on Black youth suicide. The first essentially is Durkheim's sociological approach. The 4 types of suicide (egoistic, altruistic, anomic, and fatalistic) proposed by this sociologist all relate to the poor integration of man with society.

The second model is the psychological perspective fathered by Freud, which represents anger turned on the self as a result of a lost love object. "This concept was further elaborated upon by Abraham and others to include suicide as a response to depression, which results from loss of a loved object, lost of self-esteem, or failure to attain desired goals" (p. 80). Gibbs says this theory is limited and not supported by clinical treatment of Black conscious youth who alternate between violent acting out and self destruction.

The third, the ecological perspective is offered by Holinger and Offer (1982). Their correlational analysis suggests youth suicide rates increase as the proportion of the 15-24 age group increases in the population. It is their view that the more competitors there are for the available resources and opportunities, the greater the negative effects: loss of self-esteem, failure, and eventual suicide.

The ecological approach is also extended to take into consideration the high stress of urban living referred to as the 'theory of urban stress.' This theory postulates that Black youth are at high risk for suicide because of high unemployment rate, dysfunctional families, police brutality, racism, and chaotic environments. (Breed, 1970; Bush, 1976; Seiden, 1972). These very conditions are responsible for

the high levels of frustration and hostility that set Black youth up for homicidal or suicidal behavior.

Suicide of Black youth is not the result of these ecological factors alone, according to Gibbs, since the rate of suicide did not change proportionately when the unemployment rate, for example, quadrupled between 1960-1983 (from 12.1% to 48.5%). Black female suicides remained fairly constant, and the rate for males slightly doubled in the 16-19 age group.

The concept of relative deprivation which refers to the gap that exists between the rising aspirations of Black youth and the opportunities to achieve these aspirations. As this gap widens suicide is a possibility because of the increased frustration and anger which often becomes internalized rage, frequently reaching suicidal proportions (Gibbs, 1988).

Gibbs maintains that Black suicide rates appear to be leveling off and are not converging on White youth suicide rate, contrary to much propaganda suggesting the opposite. This horrific youth phenomenon in the Black community is distressing in and of itself; however, there are other negative implications: 1) it creates a disproportionate impact on the black population which is a youthful population; 25.8 yrs is the median age, (U.S. Bureau of the Census, 1986). In addition, young Black families face a

grave situation in that there are approximately 47 employed, marriageable men per every 100 marriageable Black females.

Black males have a high rate of fatal automobile accidents and it is estimated that 69% of these accidents involve alcohol. These accidents, many in fact be 'autocides' (deliberate, self-destruction by means of an automobile).

Fatal drug overdoses are another major problem in the Black community and it is only speculation as to how many might be suicides. From 1982-1984 the number of cocaine related deaths among Black youth tripled. A 50-58% increase in PCP related deaths was recorded for Blacks between 1983-1984 (NIDA {Nat. Inst. of Drug Abuse}, 1985). Some of these overdoses were probably suicides.

In general youth suicide statistics are of questionable reliability. There is a tendency to underreport or misreport suicides as accidental or undetermined to protect families.

Victim precipitated homicide, which is quite common in the Black Community, is another area that suggests that suicide rates of Black male youths, in particular, are grossly underestimated. Aggressive anti-authority behavior of the Black Panther Movement, revolutionary actions of the Symbionese Liberation Army in 1974, which also encouraged police gun battles, and radical MOVE members in Philadelphia in 1986, who were eventually annihilated by police, are

examples of victim precipitated homicides on a grand scale. (Gibbs, 1988 in Maris, ed.).

Blacks who migrated from the South left behind a number of buffering factors that insulated against suicide, that are not readily available in Northern Urban areas, where Blacks are heavily concentrated: 1) strong families with extended family network, 2) Church, 3) Fraternal Organizations, 4) Community schools and social support networks.

In the North Black families are frequently suffering, and suicide is often the solution of choice. In most ghetto neighborhoods families are negatively affected by the deterioration of inner city schools, a decrease in church influence, and a weakening of social support systems. The breakdown of families is a serious problem. 42% of these families have female heads of household. Unemployment and welfare are commonplace, which translates into considerably less dignity, initiative, and aspirations (Gibbs, 1988, in Maris, ed.).

Gibbs states that young Black males and Black females are not socialized in the same manner in this society. This ultimately serves to influence the excessively high rate of suicide of Black male youth.

Families, as well as the gatekeepers of society (teachers, policemen, employers, etc.) provide young Black males with less positive reinforcement, less nurturance, and

fewer opportunities for social mobility than are afforded young Black females. As a result of this differential treatment, Black males are more vulnerable to suicide than Black females (Frederick, 1984).

Black youth both male and female are at considerably greater risk than their White counterparts, primarily as a result of the Black experience in America.

Herbert Hendin's classic text titled Black Suicide 1969 explores the psychic world of 25 Black patients who made suicide attempts and were hospitalized in New York City. The 13 women and 12 men ranging in age from their teens to middle age, experienced Black urban life which engenders much anger and frustration. The men and the women in the study led lives characterized by rage and violence. The theme of maternal neglect and violent fathers (when they were present) were common to nearly all of the subjects in his study.

Hendin concludes that the impact of racist institutions seems to be felt so early in life that by the time Blacks reach the teen years they already exhibit the frustration, rage, violence and despair that are often forerunners to the suicidal crisis. Hendin believes that "while the male is harder but by socio-economic pressures, it is often the female who bears the brunt of his anger" (p. 44).

It is interesting to note that the Black homicide and Black suicide rate peak during the same age period (20-35).

Hendin sees this as the "attempt by the young Black population to deal with its rage and violence."

4 of the 12 male suicidal patients were homosexual. This is a much higher incidence than in the general Black population. The fathers of these patients were violent toward both the mother and the son. The son ultimately rejected a male sexual identification which meant rejection of the violence and fear of his early life. Some of the mothers of these subjects were sexually promiscuous. This was another reason to reject a heterosexual lifestyle.

Several of the male homosexuals in their 20's and 30's blamed their mother's excessive control and criticism for turning them into homosexuals since they feared women. One patient's suicide attempt was precipitated by a fight with his mother and an attempt to give up homosexuality.

A rejection of their Blackness, which was frequently denied, seemed evident in a number of Hendin's patients. According to Hendin "preference for a White partner was common in Black homosexuals" (p. 54). One Black male homosexual blamed his "thick lips for all of his problems" (p. 58).

Many of the women in the study made attempts after being rejected by husbands or boyfriends; the current rejection resurrected the pain of earlier abandonment by their mothers.

Maternal rejection caused insecurities in these females who were skeptical about their own capacities to be mothers. If they had also been forsaken by their fathers, this added to their questioning of themselves as women and mothers.

Three of the patients were in their teens. 19 year old Vera experienced a life of crime, violence, and sexual promiscuity during her rebellious adolescence. Eddie at 18 had a life of drugs, violence, robbery, and two illegitimate children that caused him to abandon hope of changing his life. Luke, 16, and a good kid had the misfortune of needing treatment in a ghetto hospital for a fractured hip. The negligent surgeons who treated him ultimately caused a permanent limp and chronic pain. Slowly he withdrew from his friends. He felt helpless and hopeless. All of these adolescents were victimized by the Black experience in America.

Hendin concludes that the "cultures overt rejection of the Negro all too often reinforces feelings of rage and worthlessness that are already present-feelings that the culture, operating through the family, has insidiously helped produce" (p. 38).

"Suicide attempts amongst Blacks are frequently triggered by disappointments in work, careers, or relationships," which often compensate for the worthless feelings of childhood. When work or a person are used to

serve this function Hendin (p. 140) believes they are vulnerable to failure or rejection.

The Black experience in America has had a detrimental effect on the work ethic of adolescents. The Black male patients in Hendin's study had long abandoned their aspirations for careers that had been part of childhood fantasies. Their suicide attempts perhaps were the end product of feelings of hopelessness and helplessness as they came to realize that their situations would not improve through work.

Challenges to the relevancy of Hendin's views today have been put forth in the current writings on suicide since his text on Black suicide was written prior to many of the Civil Rights Movement changes in society which have impacted this group. This writer takes this into consideration; however, Hendin's findings should not be summarily dismissed as outdated until further studies (which are sorely needed) categorically refute his data. This writer believes that although strides have been made for Blacks, the high incidence of murders/suicides in the Black community suggest that societal ills suffered by many urban Blacks are responsible for many self-inflicted deaths in this group.

The tragedy of the work ethic in the adolescent Black experience brought to mind a counseling session with one of the most handsome, likeable young Black males this researcher had counseled at the high school. Jerry was

referred because school was not the place where he came to study. He carried no books, nor was he concerned about where he was supposed to be each period. His beeper and wares, perhaps a concealed weapon, and money were all he carried. Jerry was big at 15 and looked about 19. He was involved with the big time drug kingpins from Miami and at 15 was quite lucky to still be alive. He showed this writer some of his battle scars-knife wounds on his leg that had healed; but in actuality they were signs of the very short life span he was almost guaranteed.

When this researcher facetiously talked about getting his life together and thinking about a real job, (much to Jerry's amusement), he smiled and said, "Tonight I'll make 3 times what you'll make all week." No doubt he was right, but then this writer asked him a rather rhetorical question. "But, Jerry which one of is almost positive of being alive and here at school tomorrow?" Yeah, you're right," he replied. I've been shot at three times and stabbed twice." He again displayed his leg scars for effect. Jerry admitted that at times he wants out, but says he knows too much and is in too deep to be allowed out. He matter of factly stated that he would be killed if he tried to leave at this point in his "career." Jerry said he wasn't afraid of anyone, not the police nor rival dealers looking to cut into his territory. He described some close calls with the police and other drug involved individuals, and stated that

he wasn't afraid to die. This researcher wonders if in fact Jerry wasn't unconsciously looking to get out, one way or another. It is strongly suspected that he could be a victim precipitated homicide one day. When he left the office this writer felt sad. At 15 Jerry should be having fun, playing sports, maybe thinking about a real career. Given the odds, what chance does he really have at the good life that he has been allowed to taste with drug money, that surely will buy his death-literally or figuratively; but in the final analysis, is there really any difference?

The majority of Black students referred to the Crisis Center with suicidal ideation/behavior as the presenting problem were often troubled by one or more of the following problems: sexual abuse, physical abuse, alcoholism and/or drug abuse (either the student or one of the parents), homosexuality, a broken relationship, or pregnancy. In all cases other variables interacted as well to precipitate a suicidal crisis.

Middle class Black youth are frequently in conflict with the parents who want them to aspire to lofty goals and peers who are governed by anti-intellectual norms.
For those who have internalized middle class values, they are often frustrated, angered, or depressed when they find that true assimilation into the mainstream is still a myth.

Black College students at integrated schools sometimes feel shut out of mainstream social and extra curricular

activities on the college campus, which becomes a source of frustration and/or anger. According to Gibbs these young people are extremely vulnerable to suicide if the negative aspects of attending colleges where they are marginally involved are not appropriately addressed by the administration of these institutions.

Dr. David G. Gil presented at the Harvard Medical School Conference on Suicide on Feb. 2, 1990, in Boston, Massachusetts. He offered an interesting theory on suicidal/homicidal behavior in the Black community. Dr. Gil suggested looking at both behaviors as part of the same social-structural violence continuum in response to society's ills.

> The concept social-structural violence refers to patterns of social organization and to corresponding cultural and ideological tendencies which cause consistent frustration of intrinsic human needs, and which thus obstruct human development and spontaneous unfolding and actualization of people's innate capacities. Under such conditions, constructive developmental energy tends to be blocked and transformed in destructive energy which becomes manifest as counter-violence against other individuals, against society, or against the self. Crimes of violence, addictions, various mental ills, and suicide are major avenues for the expression of destructive energy . . . . The roots of social-structural violence will be traced to coercively established and maintained, exploitative systems of work and production and inegalitarian modes of distribution of material and symbolic goods and rights.

Dr. Gil's theory highlights the struggles of non-Whites in this society, and perhaps what he is suggesting is that the suicide/homicide dilemma in some minority communities is really a two-sided coin. This is also suggestive of one

aspect of Durkheim's theory on suicidal behavior: **fatalistic suicide**: the result of excessive regulation of the individual; no personal freedom and no hope; as well as Shneidman's definition of one type of suicide: "The notion of **subintentioned deaths** (Shneidman, 1973, 1981) was meant to describe a great many deaths in which the decedent has played a covert, partial, latent, unconscious role in hastening his own death."

Figures 1 and 2 on pages 104 and 105 provide statistical information on the increase in Black male and female suicide from 1968 to 1984.

Source: US Department of Health and Human Services

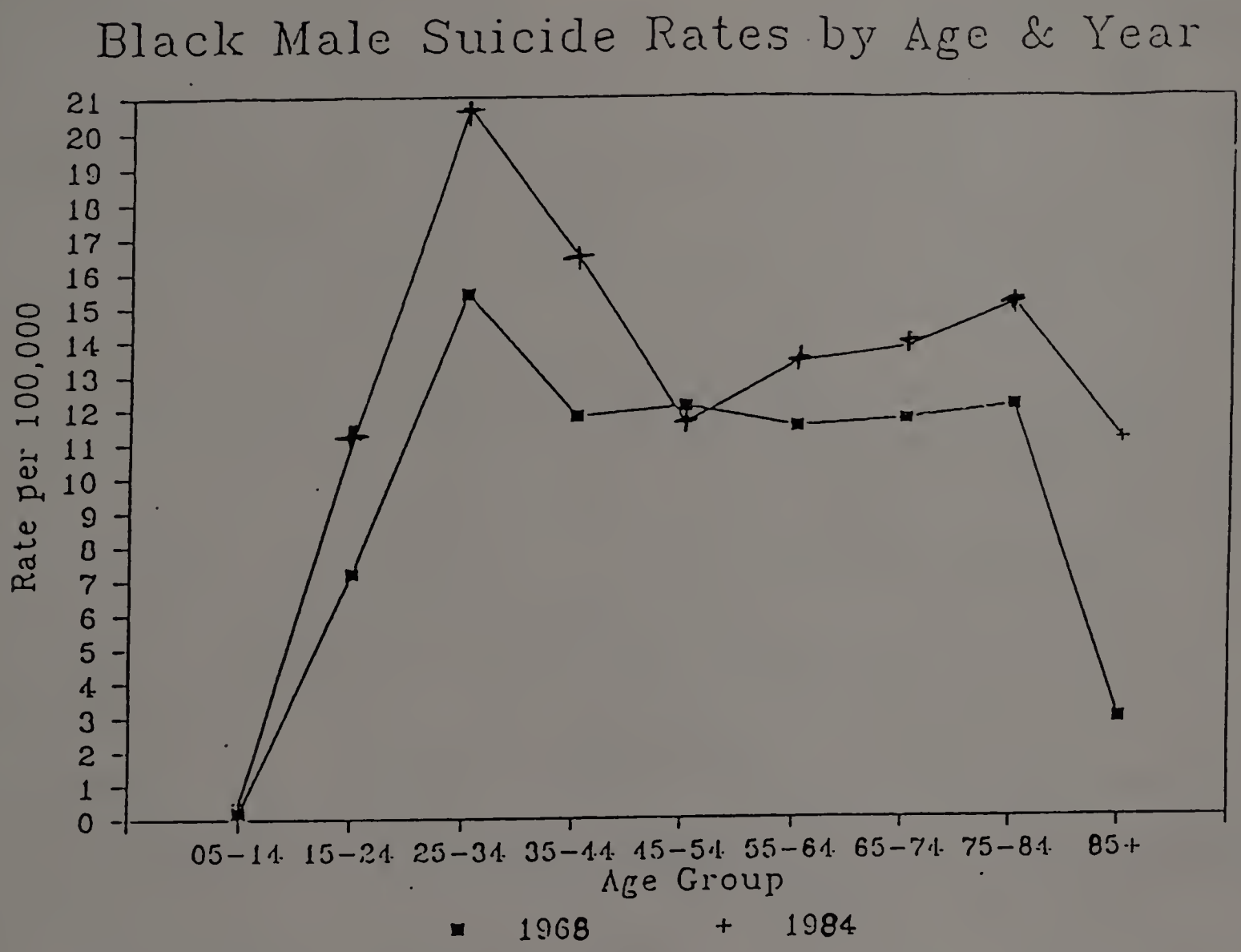

Figure 1

Black Male Suicide

Source: US Department of Health and Human Services

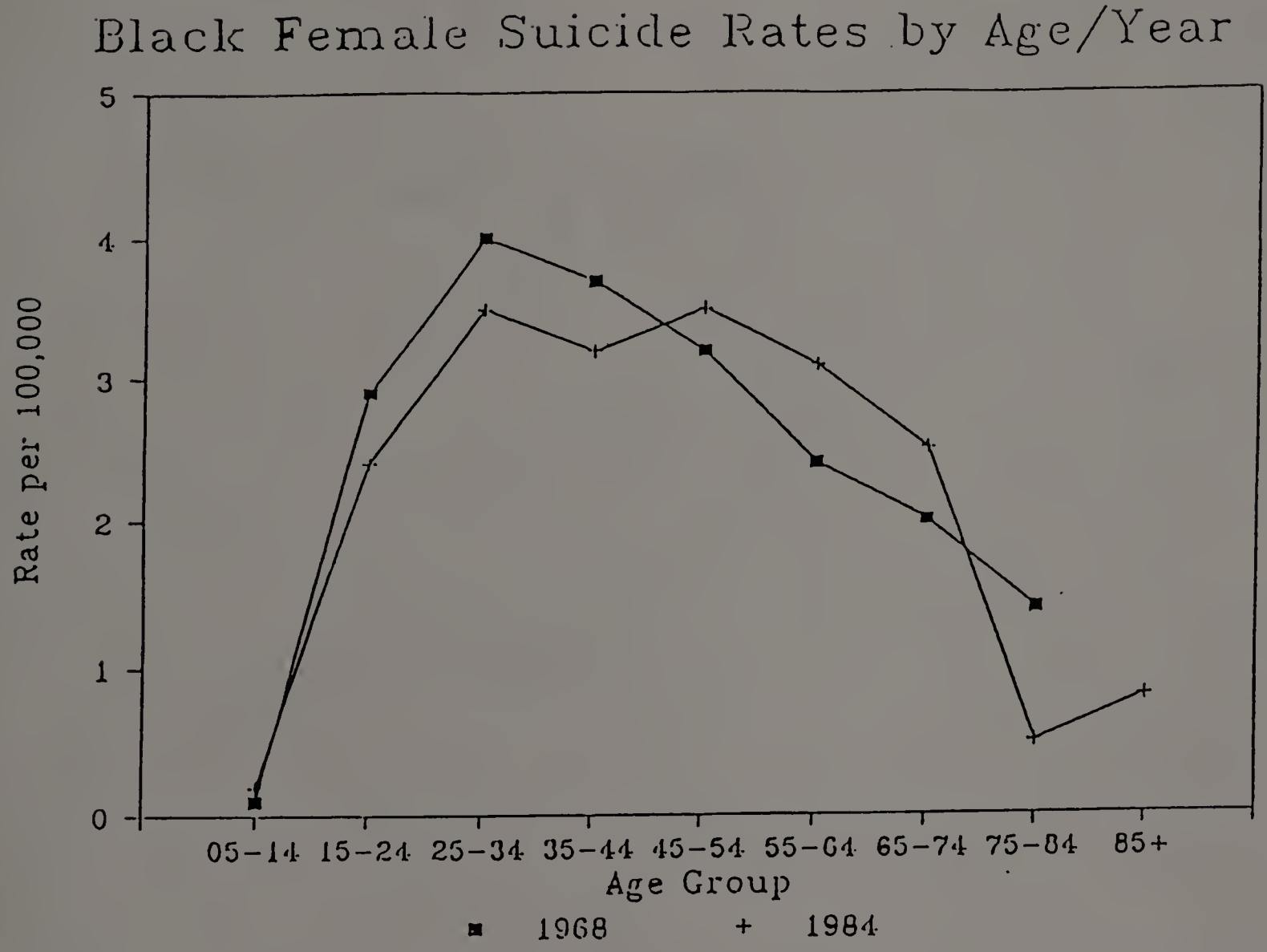

Figure 2

Black Female Suicide

Native American Suicide

Grollman (1988) characterizes adolescent suicide among Native Americans as a virtual epidemic and reports the findings of Dr. Harry L. Dizmany who investigated suicidal behavior in this group.

According to Dr. Dizmany's findings, the Native American youth "is caught between two cultures: one for which he is unprepared, the other which he feels has failed him, and toward which he has a deep ambivalence. He is neither an Indian with a sense of pride and respect for his people and his culture, nor an assimilated outsider able to identify with the culture and traditions of the dominant group." (Grollman, 1988, p. 50).

The developmental theory of adolescent suicide appears evident. In adolescence the Native American youth suffers from a diffusion of identity and 'psychological chaos' of questioning 'Who am I?' Suicide quite frequently becomes a way of gaining control over his destiny.

Hafen (1986) reports that the suicide rate for Native American adolescents on reservations has increased 200-300 per cent.

Klagsbrun (1976) made an interesting observation regarding the Cheyenne Indians. Among the northern Cheyenne warriors of yesterday, there was a traditional practice of placing oneself in a life threatening situation if the warrior for some reason had lost face of felt ashamed. This

was accomplished by doing a dangerous ritual dance. If he performed bravely and succeeded, he was elevated to hero status and regained his self-esteem. If he performed poorly and died, it was considered to be an honorable death. Interestingly, the lack of self-esteem among Cheyenne adolescents today without a traditional vehicle for regaining it, appears to be a major cause for a high rate of actual suicide amongst the Cheyenne in the last two decades. Even more astounding is that the number of attempts has increased by nearly 1000 per cent. (Klagsbrun, 1976).

Calvin J. Frederick of the National Institute of Mental Health states that the following factors are significant influences on the issue of Native American suicide: alcoholism, drug abuse, self-destructive behaviors that result from dissolution of traditional Indian lifestyles, menial jobs and low job skills; and the migration toward large cities and stress. (Hafen, 1986).

The suicide rate of adolescent Native Americans varies from tribe to tribe. The percentage of suicides and attempts are low in those tribes that are more traditional in their practices and where employment and educational opportunities exist within the tribal community, permitting youth to remain at home. Great Plains tribes that are located far from their original homeland show significantly higher rates. The Apache youth suicide rate is very high, while the rate for the Navajo youth is low.

Parental losses through divorce or desertion were much higher in incidence among suicidal Native American adolescents compared to non-suicidal Native American youth. Eighty per cent of the suicides had been arrested one or more times in the twelve months preceding the suicide as compared to 25% of the non-suicidal comparison group. (Hafen, 1986, p.12).

Philip A. May (1987) presented a paper on suicide, suicide attempts, and single vihicle crashes among youthful Native Americans of various tribes. Suicides of young Native Americans aged 10-24 years was found to be 2.3 to 2.8 times higher than the general US population, while suicide rates of older Indians tended to be lower than the general population.

Among Indian tribes studied (Plains Reservation, Intermountain Tribe, and Northwest Tribes) "those who attempt suicide appear to be qualitatively and quantively different than those who complete suicide. Specifically there are far more people who attempt suicide (about 13 to each suicide) than who actually kill themselves. Most Indians who kill themselves are male while those who attempt are female. The method of attempt is most commonly an overdose of medication while few deaths are by this means." (May, 1987, p.63).

Another interesting finding was that among the Navajo tribe, automobile accidents have been the leading cause of

death since the 1950's. This is about five times greater than the incidence of accidents in the general US population. Males are more likely to be the victims of such accidents, and the issue questioned is whether or not this is actually self-destructive behavior. Social Scientists have estimated that between 2 and 20% of all single vehicle crashes are moderately self destructive. The author stated that, "in sum, single vehicle crashes among Indian youths may hide some forms of self-destruction and/or suicide as they do in other populations." (May, 1987, p. 64).

Figure 3 below provides statistical data on the incidence of suicide amongst Native Americans. (Source: US Deptartment of Health and Human Services).

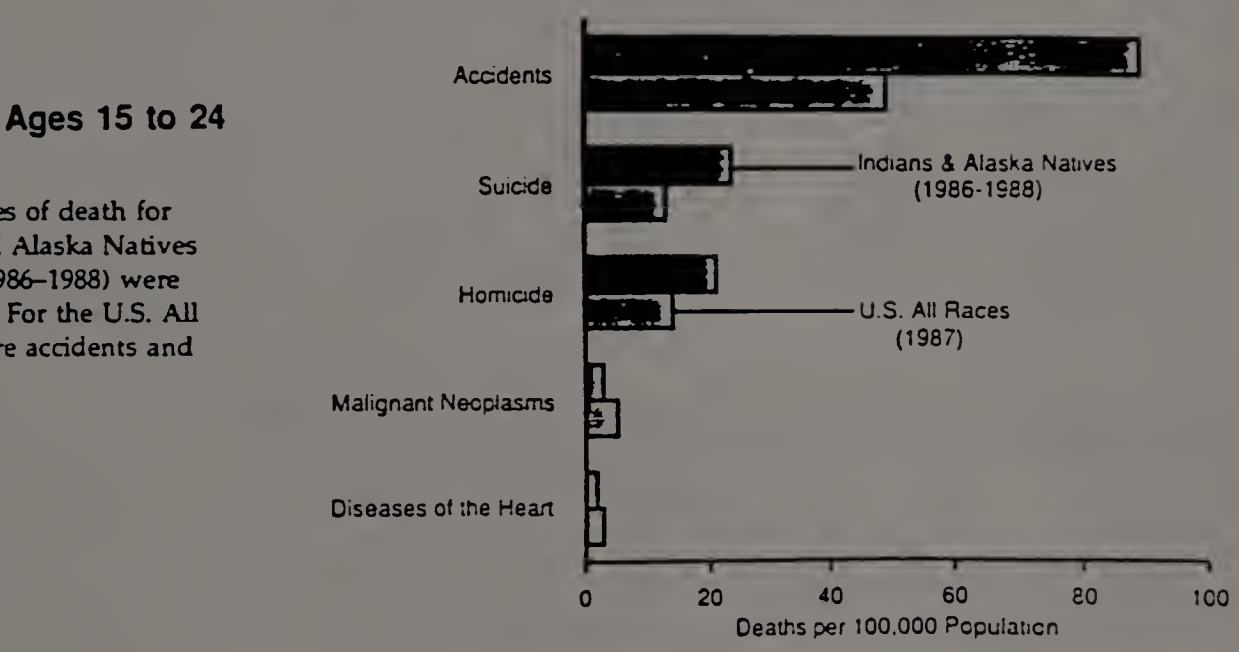

Figure 3

Native American Suicide

Suicide in Immigrant Populations

"Children of newly immigrant families were seen as caught between conflicting cultural values and patterns and as prone to isolation from peers and alienation from parents" (Grob et al., 1983, p.168). Approximately 50% of New Bedford's population is Portuguese immigrant or first generation Portuguese. The strict, overprotecting Portuguese immigrant parents often do not allow their teenage daughters to socialize in what is perceived as a society which allows too much freedom for young people. A number of Portuguese young women counseled at the high school were severely depressed for this reason. A number of Hispanic and Cape Verdean (immigrant) students were referred essentially for the same reason.

Hispanic Suicide

According to Grollman (1988) language and cultural differences in the Hispanic population are contributing factors to the increasing incidence of Hispanic youth suicide. The extended family network common to Hispanic groups prior to their migration to urban centers in mainland US is no longer available to assist the troubled adolescent.

Jack C. Smith et. al. (1985) attempted to investigate self-inflicted violent behavior in Hispanic Americans, since little data on the subject was available. Five southwestern states-Arizona, California, Colorado, New Mexico, and Texas-

were selected for their study, since more than sixty percent of the Hispanics in the US reside in these states. A comparison was made between Anglo suicides and Hispanic suicides in the area. The rate for Whites was approximately twice as high as the Hispanic rate overall. It was determined that suicides occurred at a younger age for Hispanics than Anglos. More males than females committed suicide in both groups. Authors of the study theorize that:

> Differences in the patterns of Anglo and Hispanic suicide probably reflect an interplay between the effects of the diminishing influence of Mexican cultural traditions, the increasing influence of American culture, and the marginal socioeconomic status of Mexican Americans. Horowitz (1983), in a study of culture and identity in a Chicano community in Chicago, identified two values heavily stressed in Mexican cultural tradition which are likely to protect against suicide: the concept of family honor and an emphasis on close family ties. A cultural incentive not to dishonor one's family with a sucide and the ability of close family ties to decrease the risk of social isolation may work together to diminish an individual's risk of suicide.

With assimiliation into the American culture, this may change appreciably, and as the authors point out, this factor of assimilation may account for the younger age of Hispanic victims. Older Hispanics may be so steeped in the culture that they can resist suicidal urges.

Jack C. Smith and colleagues (1986) also studied homicide and suicide among Hispanics in the same Southwest states. From their findings the authors determined that the highest suicide rates for Hispanics (18.7) are in the 20-24

year age group. This compares with a national rate of 17.1 for whites in this same age group.

The conclusion of Smith and colleagues was that suicide and homicide among Hispanics in the Southwest is primarily a problem for young males. The study also found that young Hispanic males are at almost as high a risk for homicide as young Black males. The significance of this finding in this researcher's opinion is that some of these homicides may in fact be victim-precipitated homicide or suicidal behavior as defined by Menninger and other theorists.

Sorenson and Golding (1988) studied 2393 Mexican-Americans and non-Hispanic Whites. The Mexican-Americans born in Mexico reported significantly lower age-and gender adjusted lifetime rates of sucide thoughts than Mexican-Americans born in the United States, and both Mexican-American groups reported lower rates than non-Hispanics born in the US. The authors reported that religious commitment and Catholicism have been associatd with reduced suicide rates (Durkheim, 1897/1951; Maris, 1981). "Catholic Mexico-born Mexican-Americans had significantly lower rates of suicide ideation than Catholic or non-Catholic Mexican-Americans and non-Hispanic Whites born in the United States" (p.327). The authors further concluded that stronger cultural ties among the Mexico born Mexican-Americans may contribute to their lower rates. It was also stated that "they may experience cultural constraints against thinking

about or attempting suicide or, perhaps, against talking with others about these ideas and behaviors" (p. 331). The study further revealed that US born Mexican-Americans of low acculturation were at a very high risk for suicide, more than three times the rate of Mexico-born Mexican-Americans and 25% higher than non-Hispanic Whites. The authors concluded that suicide prevention efforts are sorely needed for this high risk group (low acculturation US born Mexican-Americans), and that the Catholic Church appears to be a good intervention site since about one-half of the high-risk group attended church at least once a month.

Figure 4 below provides statistical data on Hispanic Suicide. (Source: US Dept. of Health and Human Services).

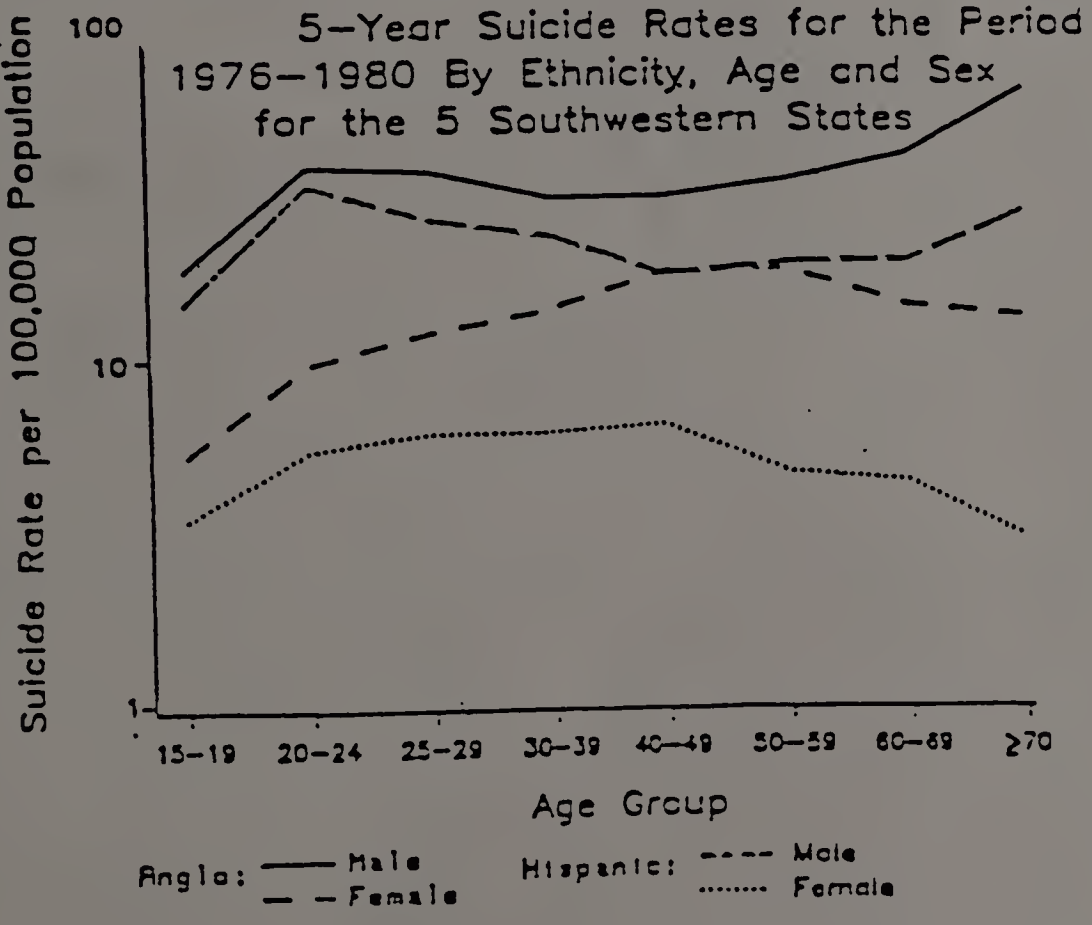

Figure 4

Hispanic Suicide

Cape Verdean Suicide

No formal research has been done on suicidal behavior in the Cape Verdean population, where it has become a concern. A Boston Globe article titled '**Suicides in the Cape Verdean Community Spur Calls for Aid**' (March 20, 1987) addresses the issue. "Seven persons have hanged themselves since November 1986 and three others, including a 10 year old girl, have attempted suicide in recent months."

Experts cite loneliness and isolation as significant variables in youth suicide. I believe that in the case of the Cape Verdean immigrant adolescent their loneliness can be felt at many levels and can be much more painful than the culturally different immigrants who are of the White majority race.

Coming from Cape Verde is often a process in loneliness that starts with the separation of family on the islands. It is not uncommon for children to have to remain behind because of economic reasons, or because of the cumbersome process of immigration. In other instances parents send their children to America to be educated, and they live with relatives or family friends.

Cape Verdean American adolescents who are second and third generation often do not associate with the non-English speaking Cape Verdean immigrant adolescent because he/she cannot speak the language, which is Crioulo, a dialect of Portuguese. Also the second and third generation Cape

Verdean-American, often identifies himself as Black and relates to the Black youth culture (music, dance, dress, etc.). Cape Verdean youth coming from the islands are immersed in their own culture and must struggle with their identity issues for some time, but primarily sees him/herself as Cape Verdean, not Black, not White, -Cape Verdean.

In addition to the difficulty relating to their American born Cape Verdean peers, the Cape Verdean immigrant adolescent is a linguistic minority and culturally different from all other groups of students, adding to the personal feeling of isolation.

The aforementioned isolation coupled with the family's strict, conservative parenting style causes additional conflicts as the process of Americanization of teens (totally unacceptable to the parents), and the developmental drive toward independence occur. This isolation and alienation can be a veritable 'suicide set-up,' and in this researcher's experience with several students it certainly has been.

During the 1990-1991 academic year six female Cape Verdean immigrant adolescents had either attempted suicide or seriously considered ending their lives. Their tragic stories demand investigation of this mental health issue in this population.

Conclusion

The tremendous amount of research strongly suggested to this writer that the complex nature of suicidal behavior is the convergence of many variables that ultimately precipitate a drive toward self-annhilation. There are human and environmental factors that are inextricably intertwined bringing about the urge toward self-destruction.

Cape Verde-A Brief Overview

Geography

The Cape Verde Islands, located about 375 miles west of the coast of West Africa, are composed of ten major islands fifteen islets divided into two groups. The Ilhas de Barlavento (windward islands) include Santo Antao, Sao Vicente, Santa Luzia (which is uninhabited), Sao Nicolau, Boa Vista and some of the islets. The Ilhas de Sotavento (leeward islands) are Maio, Santiago, Fogo, Brava and a number of islets. The land area of the island republic is 1,557 square miles, which is the approximate size of Rhode island.

Each island has its own distinct climate and terrain, however, generally speaking they are mountainous and composed of rock-filled soil of volcanic origin. The islands, with the exception of the cultivated valleys and moister highlands, have little vegetation. An active volcano still exists on the island of Fogo, last erupting in 1952. The coastline of the islands is generally high with rocky cliffs with the exception of the three salt islands, Maio, Boa Vista and Sal.

The capital of Cape Verde is Praia, a city with a population of approximately 50,000 people. It is located on the southeastern end of Santiago. Mindelo, with a population of about 50,000 people is the main port city of Cape Verde and is located on the northern side of Sao Vicente. These two cities are the major urban centers of the island republic.

Fairly even temperatures characterize the climate of Cape Verde. Seasonal variations do exist in the mountainous islands, however. The rough seas surrounding the islands are caused by constant winds from the Sahara. October to July is generally the dry season. When rains fall, generally from July to October, torrential downpours frequently contribute to flash flooding, soil erosion, crop damage and destruction of property.

Droughts and subsequent famines have been a painful part of Cape Verde's history. Records indicate especially high mortality rates during the droughts that occurred in 1773, 1774, 1810, 1830, 1854, 1863, 1900, 1920, 1940, 1946, and 1968-1985. It was estimated that 15-45% of the population perished during these climatic disasters. Thirty thousand people perished during the drought of 1946. The term 'nanhida' was coined to describe the horrible life of deep despair during these devastating times (Barrows, 1990).

History

The Portuguese claim to have discovered the islands in 1460. However, some historians acknowledge that Arab and Sengalese traders had traveled to the islands prior to this date. Early Portugese settlers consisted of soldiers and administrators from Southern Portugal. Portuguese degradados-convicts, debtors, and servants were also among the early settlers. (Barrows, 1990)

The basis of the early island economy was the Atlantic slave trade and related activities, which reached its peak during the 16th century. Slaves, providing the necessary labor, were extremely significant in the limited agricultrual development of the islands.

The development of New England in the 17th century was greatly assisted by the Cape Verde Islands. "Vessels carrying American goods sailed from New England ports to England or to the African coast, sometimes stopping in Cape Verde to buy African slaves" (American Embassy, 1987, P. 2). Later as a stopover for ship maintenance and supplies, Mindelo, on Sao Vicente, one of the three largest coaling stations in the world, developed into an important commercial center and remained so until the opening of the Suez Canal."

The economy of Cape Verde began to decline in the mid 18th century. With the end of slavery in 1878, the economy declined even further.

Portugal viewed the Cape Verde Islands as the best example of its African possessions. The islands and her people reflected the European heritage, as well as their African cultural roots. Under Portuguese rule the goal of the educational system was to encourage the development of good colonial subjects. (Barrows, 1990)

Cape Verde was divided into thirteen districts with municipal councils in all provincial and district capitols. The Governor-General appointed the presidents or camaras of the districts, while the people elected alderman.

A significant part of the Cape Verdean history is the story of emigration, which begins the story of many Cape Verdean-Americans. The droughts claimed the lives of many Cape Verdeans. The most typical response to the natural disasters of drought and famine was emigration, which continues to this day. Countries which welcomed those fleeing the islands were Portugal, Brazil, Holland, France, Germany, Italy, Argentina and the United States. Today these countries have large Cape Verdean communties. The whaling industry, as early as the end of the 18th centry, also contributed a great deal to Cape Verdean emigration. Many fine seamen from Cape Verde became whalemen and eventually settled permanently in the U.S. The largest

overseas Cape Verdean community is in the United States and is estimated to be about 350,000. Cities in Southeastern New England, New Bedford, Boston, and Brockton, Massachusetts, as well as Providence and Pawtucket, Rhode Island claim large numbers of Cape Verdean immigrants and Cape Verdean-American citizens. Most of those emigrating to the United States prior to 1922 came from the islands of Brava and Fogo. (Hirsch, Personal Communication, 8/18/89).

The United States is a very important nation to the islands. There are just as many Cape Verdeans living in the states as there are on the islands, and many of those residing in America have continued to send remittances to their homeland. It has been determined that these remittances are a major source of revenue for the Cape Verde Islands, and during austere times, this income has made a significant difference to many poverty stricken individuals. The islands were viewed by Portugal as the most 'assimilated' of Portugal's overseas possessions and this favored status meant that Cape Verdeans were chosen over other Africans for employment as civil servants in the mainland colonies.

Many Cape Verdeans, like other Africans, became extremely disatisfied with Portuguese rule. The results of five hundred years of colonialism was devastation and mass migration. The history is replete with the callous

exploitation by Portugal, and endless cycles of drought, famine, and misery (Barrows, 1990).

While Portual governed the islands only 27% of the population had access to education. The fishing industry stagnated, and agriculture on the islands, which was never fully developed, was nearly wiped out.

The unrest and disatisfaction with Portuguese rule culminated in Cape Verdeans joining forces with the Partido Africano da Independencia da Guine e Cabo Verde (PAIGC). The PAIGC was founded in 1956 in Portuguese Guinea by Amilcar Cabral (whose father was Cape Verdean) and a Cape Verdean who would later become Cape Verde's first president, Aristides Pereira. He was responsible for the party's security and intelligence operations.

A new phase of the struggle began with a generalized armed rebellion in Portuguese Africa which commenced in 1961. The Cape Verde islands were kept under tight control by the Portuguese military and police. No fighting took place on the islands; however, many Cape Verdeans crossed over to the continent to aid Portuguese Africa in their struggle for independence. A low point in the battle for independence came when Amilcar Cabral was assassinated in 1973. The struggle against the Portuguese government continued, however, and on July 5, 1975 Cape Verde became an independent nation.

Initially Cape Verde and Guinea Bissau were governed jointly by the PAIGC. The efforts to keep the two former Portuguese possessions united ended abruptly in 1980 when president of Guinea-Bissau, Luis Cabral, brother of Amilcar Cabral, was overthrown. Following that coup the party in Cape Verde changed its name to PAICV, the African Party for the Independence of Cape Verde.

There have been many positive changes since independence in this struggling Third World country. Portugal's neglect left a legacy of no agricultural or industrial base, high unemployment, poor health conditions and a very high illiteracy rate.

Under colonial rule only 27% of the population had access to education. Today nearly 100% of the youth population has access to education at the primary level.

> The present educational structure guarantees four years of primary schooling followed by two years of preparatory education. Secondary school and some limited technical education is then available to those who qualify. There is no univdersity, but a teacher's college is already operating. Those seeking higher education pursue it abroad, most often in Portugal, the U.S. or Europe. (American Embassy, March 1987, p.11).

Hospitals and dispensaries have been constructed on every island, and for many health care has become available for the first time. (Barrows, 1990). The life expectancy for women as reported in 1987 was 63 years and for men 60 years; this is approximately a fifteen years increase in the last ten to fifteen years. (American Embassy, March 1987). Infant mortality has been reduced dramatically since 1975.

Society and Culture

In Brief: The population of Cape Verde (July 1988) is approximately 353,885. The people of the islands are 71% Creole (mulatto), 28% African, 1% European. Most of the population is Roman Catholic with indigenous beliefs infused. The native language of the people is Crioulo, a blend of Portuguese and West African words. The official language of the republic, however, is still Portuguese.

> Racially and socially the Cape Verdes are very much a creation of the slave trade. The slave trade was the instrument that made of the sparse islands of the Cape Verdes a field of collision, and also of cooperation, between African and European. White and Black entered into a series of complex interactions that involved oppression and collaboration, cruelty and concubinage, mutual accomodations and intermarriage, and much else (Duncan, 1972, p. 195).

The European and African mixture extends beyond merely the genetic; sociocultural patterns reflect both the African and the Portuguese. The role of women, in particular, suggests both the African and Europopean traditions.

Cape Verdean 'machismo' clearly indicates a lower status for women in relation to men. Traditions from the colonial past, and an antiquated form of colonialism is responsible for this lower status. During slavery, men were preferred over women as slaves, and slaveowners used female slaves as concubines. Historically, men were favored and had opportunities for education, employment, and emigration that were not as freely accorded to women. Other factors

that contributed to the lower status of women were the 'Catholic Church, with its rigid hierarchy based on the predominance of males' and the large scale emigration of men some of whom became whalers and settled in New England, which resulted in a skewed sex ratio in the islands; there were "many more young women for a limited number of older men" (Barrows, 1990 p. 256).

Although there is an attempt to improve the status of women in the islands under the new government, progress is slow. "As of February 1990 no women had been appointed to the Council of Ministers. Of the one thousand members of the National Assembly only six are women. No women have been appointed ambassador to a foreign country." (Barrows, 1990, p. 260).

This cultural tradition of male dominance was a major culture clash issue for the young women in the study. They clearly resented their male relatives attempts to safeguard this tradition of male superiority, which they sought to leave behind in Cape Verde, once they acquired more liberalized values pertaining to the role of women in this country.

Suicide in Cape Verde

The review of the literature on Cape Verde revealed no information on suicide in the islands, other than one historical account that this writer feels is worthy of note.

Antonio Carreira (1982) sites the problem of suicide in a report written by the then Secretary-General of the Cape Verde Government, Eduardo Augusto de Sa Noguira Pinto de Balsemao dated 13 September 1874:

> On the island of Brava... there is a great disproportion between the male and female sexes. Apart from any reasons which physiology might explain, this arises because a large part of the male population yield to their dominant passion and embark on board the whaling ships to obtain a more satisfying way of life. Many certainly return with their dreams fulfilled, but a good many of the emigrants (if the may be so called) stay and settle there. Not less than a hundred, on average, leave the island every year, throwing themselves on the wings of fortune in search of an uncertain future, which an uninterrupted series of accidents and dangers makes even more uncertain. And this propensity for a maritime life is not just limited to taking service on whaling ships; even our own men of war have no difficulty in getting sailors from Brava. On the other hand one cannot stress too much their horror of military life on land; there are regular instances of them mutilating themselves, jumping into the sea or throwing themselves off cliffs, solely because they do not want to be enlisted as soldiers; for the people believe unshakeably that anyone who agrees to be a soldier is irrevocably lost. ... (p.48).

A number of the Cape Verdean professionals who were interviewed, particularly those who were born in the islands, feel that suicide is not a frequent occurrence in Cape Verde, and certainly feel that it is an adult problem when it does occur. They strongly suggest that adolescent

or youth suicide is virtually non-existent in the republic. With regard to Cape Verdeans in the states, it is believed by many that it is an adult problem.

A March 20, 1987 Boston Globe article highlighted this problem.

> Joanne Barboza, a social service consultant and a cofounder of the Cape Verdean Community House in Roxbury, said earlier this week that seven persons have hanged themselves since November 1986 and three others, including a ten year old girl, have attempted suicide in recent months. Others reported five suicides in Boston, one in Falmouth and two in Pawtucket, Rhode Island."

Joao Pereira stated:

> In Cape Verde in the last 50 years all the cases of suicide are adults, and normally for cases of honor. Suppose a girl got pregnant and the boyfriend didn't marry her, and now to save the honor of the family she kills herself. This sometimes happens in Cape Verde. If someone embezzled in the workplace and now it is found out, to save the honor of the family, they kill themselves sometimes. But it is very rare in Cape Verde. For life stress, not too many cases, like someone lost a job, no; they can cope with the situation. Here in the United States, maybe because of life stress because of a different environment adults have (committed suicide), more the Portuguese and the Spanish population in New Bedford than the Cape Verdean population. I know that in Boston four or five adults hanged themselves."

Padre Pio offered these words on the subject:

> We had four or five years ago five suicides in a few months of old people, not young people in Boston (1987).The biggest problem is more the grownups, because they can't adapt to the lifestyle here in the US and they can't go back; the problem is they're not happy here but they can't go back to their country because they've given up everything. I have not seen a lot of suicidal problems with teenagers; mostly with older people. I know a lot of families who have packed up and gone back; they suffered too much; they said that while they were here in the US they lived a rich life; they had everything, but they didn't have that

> family structure like they did in Cape Verde. They wanted to go back where they would be poor, but at least they would be in peace.

These spokespersons offered a very specific reason for the low incidence of suicidal behavior amongst Cape Verdeans. Most Cape Verdeans are Roman Catholic, and there are a good number who are members of the Church of the Nazarene in the population. Both religions offer strong counsel against suicide. Besides these major religions, it should be pointed out that there are additional beliefs by the populace that reflect spirtitualism with some African influences that persist both in Cape Verde and in Cape Verdean-American communities. There are many superstitions and fears of the spirit world, even by those who regularly practice the traditional religions. It was the consensus of those interviewed that religion is the greatest deterent to suicide, since it is considered a sin, and is most effective in keeping the incidence of suicide and suicidal behavior relatively low, both in Cape Verde and in Cape Verdean communities in the United States.

Joao Pereira expressed the following:

> In the Cape Verdean population the religion is very, very important. Almost all of the Cape Verdeans are Catholic or Nazarene, and all those religions forbid that you cannot take your life because it is against god's will, and because of that maybe they avoid it. Cape Verdeans are afraid of death and God. They believe in hell. And they know that priests and ministers say that if you kill yourself, you will go to "hell" and not "paradise." Cape Verdeans, even if they tell you that they are not religious, they are afraid of God. Also, in the case of suicide you cannot have a

> religious funeral, because the priest refuses to go the funeral. It's against the policy of the Catholic church. I remember when I was young, instead of having the priest they had music. (Personal Communication, 1/8/92).
>
> Dr. Maria Rodrigues stated that:
>
> Catholicism is a major influence; there are very strong feelings about suicide. It's believed that the soul would not be saved, and the individual is doomed to eternal damnation and suffering. Some individuals feel so strong about suicide that they might choose not attend funeral rites. Some priests, certainly in the old country, might not say mass at the funeral. (Personal Communication, 2/17/92).

Antonio Gonsalves' comment was extremely suggestive of the major influence of religion for Cape Verdeans:

"I'm third generation and it (religion) impacts my thinking. My religious upbringing is that you don't go to heaven if you kill yourself." (Personal Communication, 1/8/92).

One of the young women who attempted suicide spoke about the religious views brought to her attention following her attempt. A portion of the transcript is offered:

STUDENT: After I took the pills a lot of people were scaring me about not being with God.

MARLENE RODERIQUES: who?

STUDENT: My older sister. She was here from Cape Verde; there's this church here you go to; I don't really think it's a church. I don't think god would like it. You go there and there's these spirits; these spirits are chained, and these spirits are people who committed suicide, and there there, and the priest asked them why did they do it, and they have to talk. They have to explain to people so people won't commit suicide. And after they've been talking and all, they're all clean and they could go to heaven.

MARLENE RODERIQUES: Were you taken to this place?

STUDENT: No. They wanted me to go; and I said no, not me. My sister wanted me to see that people are not supposed to commit suicide, cause they'll never rest in peace. And I said, 'how am I going to see that?' And she said there's this church, cause someone brought her there. I guess she wanted me to see so I could see how it is so I won't try to do it again.

MARLENE RODERIQUES: Where is this house?

STUDENT: in the north end

MARLENE RODERIQUES: What is in this house?

STUDENT: There's spirits there, but they are chained; of course you can't see spirits; but they talk; the ghost could talk. And plus if something is going wrong in your life they'll know, and they'll tell you to go up there because they don't want you to do the same thing. I don't know how they know, but they'll call you up there.

MARLENE RODERIQUES: Who will call you there?

STUDENT: I think the priest will call you up there. Cause the ghosts knows; it's weird.

MARLENE RODERIQUES: So your sister wanted you to go.. and what did you say to her?

STUDENT: I said no; I was scaired, but I always want to try new stuff, you know.

MARLENE RODERIQUES: Did this affect your thinking about whether you would do this again?

STUDENT: Yes. It did. I got real scaired. I said no way; I don't want my spirit to be walking around; I want to rest in peace when I die. I want to be with God. uh, uh. It's not....I learned a lot from what happened. I don't know; you shouldn't take life...cause see, I used to do things; no one cared; so what am I going to do. I wanted to die; what's the sense of being here?... if no one wants to believe something that I'm trying to say. And it's not really like that; you'll find someone, cause someone...like I found you and Ms. ...(name of Guidance Counselor). And I found my older sister; and if you don't find that someone, God will be there, God will always be there. I didn't feel this at first.

This researcher found it most interesting that many of the professionals interviewed and many of the students spoke of the frequency of suicides amongst Cape Verdeans from the island of Fogo. Also, each of the suicides in the Boston rash of suicides in 1987 was an immigrant from the island of Fogo.

Alcides Pina (Personal Communication, 12/11/92) informed this researcher that:

> Suicide in Cape Verde, the percentage is low. Fogo has the highest incidence of suicide, and I noticed that students from Fogo exhibit suicidal behavior more often than students from the other islands."

Padre Pio (Personal Communication, 12/29/92) made the same observation:

> In Cape Verde, which is very difficult to understand, almost all the people who commit suicide are from Fogo.

Dr. Rodrigues (Personal Communication, 2/17/92) also discussed the more frequent occurrence of suicides on the island of Fogo:

> Some individuals believe that the people of Fogo tend to be very sensitive and perhaps more emotional, but there's no data on this officially.

One student offered an interesting explanation for this Fogo phenomenon:

> Mostly people from Fogo kill themselves, and some people say it's because of the volcano. I know about this man who worked in the school library where they sell the books. He gave the money from the store to his friend to come to America. His friend promised to give the money back before he had to enter it into the books, but when the day came the friend didn't give the money. The man was from Fogo, but it happened in Praia. The man from the store hanged himself; I knew three

people who killed themselves and they were all from Fogo.

The overview of Cape Verde presents a culture and people of this island nation who have struggled and are still struggling to survive. Cape Verdeans are a multi-racial people whose language and culture reflect their Portuguese-African roots. The inhabitants of this tiny third world republic are a very proud people. They gained independence on July 5, 1975 after 500 years of Portuguese colonialism, droughts and famine.

Throughout their history emigration has been the most frequent response to the hardships of life in Cape Verde. The United States has been the destination of many emigres, and this began the settlement of Cape Verdean-American communities.

According to knowledgeable Cape Verdeans suicide is not a common occurrence primarily because of the strong influence of religion or the Catholic Church. Cape Verdean immigrant adults who have committed suicide appear to have been victims of a stressful adjustment to a foreign land and culture quite different from the homeland and its traditions.

Suicidal behavior in the Cape Verdean immigrant adolescent population is a concern to a number of the professionals and families from this community. However, there are differing opinions as to the severity of the

problem. Despite this difference of opinion on how extensive the problem is, it is clear that this mental health issue warrants attention and remedy.

CHAPTER 3

DESIGN AND RESEARCH METHODS

Overall Approach

The purpose of this qualitative research study of suicidal Cape Verdean immigrant adolescents was to identify possible causal/contributing factors of their suicidal behavior. This researcher utilized **qualitative methodology.** Patton (1990, p. 18) states that qualitative methods are well-suited to yield "depth, detail, and meaning at a very personal level of experience."

A **case study approach** was employed to answer the research questions. Yin (1989, p. 13) states that

> In general, case studies are the preferred strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context.

Borg and Gall (1983 p. 489) define the **clinical case study**, which further defines my research approach, as follows:

> This approach is aimed at understanding a particular type of individual, such as a child with a specific learning disability. Such case studies usually employ clinical interviews and observations but may also involve testing and other forms of data collection. The usual goals are to better understand the individual and the disability and identify possible treatments.

This researcher also chose a qualitative method exclusively, rather than attempt to use quantitative research methodology in whole or in part, for a very critical reason. Although it might be assumed that large samples would lend more credibility to research findings, the sensitive nature of the topic, **adolescent suicide**, shouts "caution" to any researcher. This writer wanted to interview students, and not rely strictly on the reporting of significant individuals in the lives of the troubled youths, since suicidal adolescents are responding to their perceptions of their reality, and not the reality as perceived by their families or the professionals who work with them.

Shreve and Kundel (1991) spoke to this very issue:

> It is also most important to consider the subjective sense of the adolescent vis-a-vis his or her family and social environment. It is the adolescent's perception of the environment, family, and support system that is most important, not the apparent reality (p.309).

Soliciting data from other respondents was critical, but the essential material would come from the students themselves. With this primary concern, and the concern for the safety and well-being of the young people selected, it was concluded that only certain subjects who had been counseled by this researcher for suicidal behavior, and who could continue to receive support, would participate in the study. Given the fragile nature of many students who have life situations that often precipitate suicidal actions, and

the impulsivity of teens in general, this author had concerns that investigative questions, which could possibly dredge up painful pasts and unpleasant feelings, could possibly precipitate depression, or another suicide attempt.

For this reason great care was exercised in the selection of students. It was necessary to eliminate two potential subjects at the time of decision-making for the subject selection process, since their emotional state was questionable, and their lives extremely unstable.

Dr. Nancy Baron (1989 p. 182), during her research process of investigating **Suicidal Risk in Learning Disabled Adolescents,** experienced the very problem that this researcher had hoped to avoid and stated the following in her recommendations for future research:

> This author found that interviewing potentially suicidal subjects was complicated. A substantial number of the youths in the study were found to be at risk and the author needed to use her crisis intervention and clinical skills to handle these difficult situations.

Another factor involved in the decision to opt for a qualitative case study with students known to this researcher was the very real possibility that it would be difficult to obtain reliable data on such a sensitive topic from students in other communities not known to the investigator.

Over and over again in interviews with key people (Gonsalves, Pio, Pereira, Evora, Pina), this researcher heard the following: The Cape Verdean immigrant is not

going to talk about suicide, especially to a stranger. It is a sacrilegious thought; it is foreign to the culture.

The study used the methodology of interviews and observations primarily; in addition, all cumulative records of students involved in the study were reviewed. Three Cape Verdean immigrant adolescents who had manifested suicidal behavior and who had been counseled by this researcher, and three Cape Verdean immigrant adolescents who had not ever presented as suicidal, and who appeared well-adjusted were interviewed. All of these students were in the Cape Verdean bilingual program at New Bedford high school. Interviews with significant professionals, one of each student's teachers and each student's guidance counselor were completed. Interview questions were designed to elicit responses to ultimately answer the research questions that guided the study. In summary, the questions sought to discover what theoretical paradigms and/or psychosocial contributing factors were evident or suggested by the individual cases. The questions covered the following areas: family adjustment, parent loss, family conflict, parent characteristics, health and emotional problems, school adjustment, social relationships, peer pressure, substance abuse, situational factors, cognitive functioning, emotional adjustment, and racial and cultural factors. A comparative study of the suicidal and non-suicidal students helped illuminate answers to the research questions.

The Setting

New Bedford High School, the largest high school in Massachusetts, is located in the Northwestern section of the city. It is a beautiful, well-maintained physical plant that belies its 19 year existence. There are approximately 3200 students and approximately 350 full time staff members. The student population reflects the racial/ethnic mix of the larger community. The approximately 106,000 residents who tend to hold on to their cultural heritage, are Portuguese, French, English, Polish, Irish, Lebanese, Italians, Scandinavians, German, Greeks, Afro-American, Cape Verdeans and Hispanics. About twenty-two per cent of the student body is foreign-born and comes from homes where English is not the first language. Twenty-four percent of the student body is classified as Minority population.

Cape Verdean students defined as immigrant are those adolescents whose primary language is "Crioulo" (pronounced "Creole"), and those who were born in the Cape Verde Islands. According to the November 1990 school census 66 students would fall into this category. There are also a large number of first, second, and third generation Cape Verdean students in the high school; however, the census records most of these students as Black. They are a significant percentage of the 380 Black students on record. A good number of Cape Verdean-American students, based on

their physical appearance, are counted as White. For these reasons, an accurate count of Cape Verdean students is difficult to determine.

This site becomes the obvious choice for two reasons: first, the City of New Bedford has only one public academic high school. Therefore, most Cape Verdean immigrant students would be in attendance at this school. Secondly, this researcher has been a **Crisis Counselor** at this high school, and in this position became aware of and involved with Cape Verdean immigrant students manifesting some level of suicidal behavior.

All interviews and observations were completed in the high school: in the students' classrooms, guidance offices or the Crisis Center office.

Interview Guides and Observational forms are in the appendix.

Population of Study

The population of focus for this multiple-case study included six students; three Cape Verdean immigrant adolescents in attendance at New Bedford High School, who were referred to this researcher/counselor at some time during the 1990-1991 academic year for manifesting serious suicidal behavior, and three Cape Verdean immigrant adolescents who appeared to be well-adjusted (in the opinion

Catholic, one as Catholic and Nazarene, and one as Protestant.

The guidance counselor and one of each student's teachers were also interviewed.

Of paramount importance to this researcher, was the pledge to students and parents to protect the identity of the subjects involved. Given the relatively small number of students that make up the Cape Verdean Bilingual classes, the internal familiarity of the closed community of Cape Verdean immigrants, and the idiosyncratic details that could make it very possible for informed individuals to know the identities of students, it was ultimately decided to to offer limited individual case study narratives, and to present aggragate data as completely as possible, with the hope that this decision would not detract from the dissertation as a whole. The limited case studies of the students will precede the findings.

Procedures

This researcher first spoke personally with the Headmaster of the High School about the proposed study, in order to determine his receptivity to the project. He readily approved the dissertation proosal. After an initial telephone conversation explaining the proposal, a letter of request to do the research and a copy of the proposal were

submitted to the Superintendent of Schools and the School Committee of New Bedford for approval. Permission to do the study was granted, and subsequently contact was made with each of the three students who had been suicidal in the past, and the proposed project was explained to them. Each of these three students said yes and seemed pleased and excited about the study. Next this writer met with the Cape Verdean bilingual teacher to discuss and select three students who seemed well-adjusted, and who had not, to his knowledge, manifested suicidal behavior. After discussing several possibilities, two students known to the author were selected. The third student suggested for the study was not known to the author. This researcher met individually with each of these students and explained the study to them. They were eager to participate. The parents were contacted next and the proposal was explained to them. Some of the parents (in one instance, the grandparent) did not speak English. The bilingual teacher, explained in the native language of the family. In one instance, this researcher did the translating.

Interviews

Two interviews with each student, which totalled two and one-half hours, were conducted at the high school. These sessions were tape recorded. One interview with the

professionals involved with the students was conducted by this researcher and recorded on audio-tape. These interviews took from forty-five minutes to two hours. The student interviews were completed during the month of September 1991; the guidance counselor and teacher interviews were taped during the first week of October 1991. The instruments used for all interviews can be found in the appendices.

The student interview is a combination of an interview guide that was developed by this researcher with some questions or parts thereof from an interview guide developed by Dr. Nancy Baron and found in her dissertation, A Systemic Analysis of the Critical Elements of Self-Image and the Propensity to Suicidal Risk for the Learning Disabled Adolescent.

Observations

Data was collected from observations by guidance counselors and teachers. This researcher also utilized observations from counseling sessions with the students who were counseled at the Crisis Center. Teachers and guidance counselors were asked to record observational data on a form provided by this writer. Observational forms are in the appendix.

Review of School Records

All cumulative school records of the students were reviewed as part of the research study.

Data Management

All of the interviews for the study were audio recorded and subsequently transcribed.

Case notes and observational data were hand written. This author was able to record student counseling sessions with their consent on many occasions. At no time were sessions taped when doing so would have been callous or intrusive.

Records review of students was accomplished by note taking and duplicating.

Data Analysis

Marshall and Rossman (1990 p. 113) state that

> In qualitative studies, data collection and analysis go hand in hand to promote the emergence of substantive theory grounded in empirical data. Glaser and Strauss (1967) and Vidich (1969) expand on this process. The researcher is guided by initial concepts and guiding hypotheses, but shifts or discards them as the data are collected and analyzed.

The data analysis process that this writer utilized and found most comfortable is essentially a guide outlined by Taylor and Bogdan (1984), and basically the process included the following steps:

1. Keeping track of themes, hunches, interpretations, and ideas. Any thoughts and ideas that came to mind while reading the data were recorded.

2. Looking for emerging themes. This phase involved a search for themes and patterns, paying particular attention to conversation topics, vocabulary, recurring activities, meanings, feelings, etc.

3. Construct typologies. A classification scheme was developed for identifying themes and developing concepts and theory.

4. Developing concepts and theoretical propositions. A perusal of the data generated concepts, and propositions. Identified themes were examined closely to determine if underlying similarities existed between them.

5. Reading the literature. Taylor and Bogdan state that:

> It is important to expose yourself to theoretical frameworks during the intensive analysis stage of the research. ...Although most researchers align themselves with a specific theoretical framework, it is standard to borrow from diverse frameworks to make sense out of data (984:134-5).

This researcher found that searching out diverse theoretical frameworks was essential, since no one theory can completely explain adolescent suicide.

6. Coding the data. All notes transcripts, documents and other material were coded. This researcher tried at all times to apply the cardinal rule offered by Taylor and Bodgan "make the codes fit the data and not vice versa" (1984:137).

7. Sorting the data into the coding categories. Although this was more or less a mechanical process it helped in the critical process of refining the analysis.

8. Refining the analysis. By coding and sorting the data, it was relatively easy to compare different pieces of data relating to each theme, concept, and proposition, etc.

9. Discounting the data. According to Taylor and Bogdan (1984) this essential phase must be undertaken with great care. It is their opinion that all data are potentially valuable if we know how to assess their credibility. These authors suggest taking the following factors into consideration.

a. whether data was solicited or unsolicited

b. observer's influence on the setting

c. presence of other people may influence data collection

d. direct and indirect data; inferences based on indirect data may be of questionable validity.

e. your own assumptions and presuppositions

This researcher attempted to take these factors into consideration.

Notes on thoughts, impressions, and insights were made as this writer proceeded with the data collection. Comments and other information offered by the interviewees which were not directly given in response to interview questions were also considered in the data analysis process.

CHAPTER 4

RESULTS

The purpose of this qualitative case study was to identify possible causal/contributing factors of the suicidal behavior in several cases of Cape Verdean immigrant adolescents, and to determine if commonalities existed in this target group. The data collected are presented in this chapter. The research questions that guided this study were:

1. What possible causal/contributing factors are present in the case studies of those students who exhibited suicidal behavior?
2. What are the precipitating events in these cases of suicidal behavior?
3. Are there any commonalities in the causal/contributing factors in each of the cases of students who manifested suicidal behavior?
4. What differences are noted when a comparison is made between the group of students that has exhibited suicidal behavior and the group that has not exhibited this behavior?

The following case study narratives precede the data collected.

Diana

Diana was 14 years old at the time of the study and came to this country in 1985 at the age of 9. Her parents were married, and she has 5 sisters and 4 brothers. She is the youngest daughter and according to her, very close to her father, whom she apparently adored. Her father died when she was seven years old, and his death has affected her life considerably. She stated that she was not directly informed of his death by family members because she was quite young, and only learned of it accidentally. Shortly after her father's death, Diana's mother left for the United States with some of her siblings and she, as well as several other siblings, joined them in this country two years later. While in Cape Verde after her mother's departure, Diana was left primarily in the care of a close family friend, while her siblings resided with other relatives and friends. She did have contact with her siblings, but was basically living away from them, in a home where she felt uncomfortable. In the United States Diana began elementary school in a bilingual program and did well. She likes school. Her family relationships have been very strained, since she, over the years has become quite Americanized. Additionally, she was sexually abused by an individual outside the family,

and this problem caused internal family dissension. She feels very isolated and distant from family members. Substance abuse and a sexual activity have been concerns of family members and the professionals who have been involved with her.

LIDIA

Lidia was 19 years old at the time of the study. She came to this country in 1986 when she was 15 years old. Her mother came to the United States in 1981 when Lidia was ten, and she remained in Cape Verde with her father and siblings. Lidia reported being very close to her father, and not remembering her mother very well, since they were separated for a number of years after the mother came to the United States. Lidia, like Diana, lost her father. In 1985 he died while on a trip to Portugal. He had gone there hoping to buy a house. Lidia had expected to go to live with him in Portugal, while some siblings were going to America to join their mother. Her father's death was especially painful, according to Lidia, because she was unable to say 'goodbye.' He died and was buried in Portugal, which precluded the possiblity of her attending wake or funeral services. In addition to this hurt, she reported that she had been unable to say goodbye to him when he left for Portugal the last time. Just prior to his leaving Cape Verde, they were all visiting relatives and she was

separated from him. When she returned to the place where he was supposed to meet them prior to departure, he had already left; this final parting, lacking in a formal and loving farewell, caused her additional sorrow.

Following her father's death Lidia lived in a number of places before getting a departure date for America. The family was very fragmented, leaving her with a number of caretakers. When older siblings were in charge at various times, they were frequently irresponsible with money her mother sent from the United States for their care. At times Lidia, still just a young girl herself, was responsible for younger sibilings who were left in her care.

Lidia reported that at first her mother was glad to have all of her children in America. The family, she says, was not close, however, and she felt that her mother didn't care for her. She had started junior high school in the Cape Verdean Bilingual program, but had to quit school to go to work in order to buy her own clothes and other necessities per order of her mother. She worked for some time, and then did return to school upon the encouragement of a teacher who felt she had good potential. Lidia likes school and hopes to graduate. She takes care of her own personal needs.

According to Lidia home life was difficult with a strict mother. Her older brothers physically abused her when she wanted to go out with friends. Eventually she also

suffered physical abuse from a boyfriend. Lidia left her mother's home to make her own way, and she has done quite well independently.

MELINDA

At the time of the study, Melinda was nearly 18 years old. Her parents had not been married and she lived with her mother for the first few years of her life. According to Melinda, she was brought to her paternal grandparents home by her father's sisters, ostensibly for a visit, per orders of her father. However, she was never returned to her mother and was convinced that her mother had abandoned her. She speaks of an abusive childhood with her grandparents. Her mother eventually found her living on a different island, and she lived with her again for a short while. However, she returned to her grandparents home, since she missed them. Eventually she was sent to live with her father in America in 1988 at the age of 14. He had been living here for many years.

Life with her father in the US was difficult; he was very traditional and Melinda wanted some freedom. She eventually left his home feeling responsible for his marital problems. She is now on her own and struggling to make a decent life in the US. She wants to graduate in order to make a better future for herself.

JOSE

Jose was 17 years old when the study began. He came to this country two years ago to join his father who had been living in the US for the past fourteen years. Jose speaks well of his mother who is still in Cape Verde. He loves her dearly and expresses appreciation for the life she provided him in his homeland. According to Jose, he and his mother talked a lot together. His parents were not married; he has two sisters who are living in America and two brothers still living in Cape Verde. He is the oldest child and assumed a great deal of responsibility while living with his mother. Jose misses his mother very much, and an important goal for him is to bring her to this country. Jose works after school and sends money home to his mother in Cape Verde to assist with the care of the family. Jose loves attending school in this country and speaks glowingly of the opportunities in America.

MARIA

Maria, who was 14 years old at the time of the study, was the youngest student selected for participation. At age 12 she came to this country to live with her father, step-mother, and half-sister, and has been in the United States less than two years. Although her parents were not married, they provided a loving environment in her early years in Cape Verde. According to Maria, she was adored by

both her parents, and she reciprocated in returning those loving feelings. As a young child Maria's mother began to instill in her the importance of honest, open communication between them, and she speaks of excellent communication at home.

Her mother involved her in many different types of activities in Cape Verde: singing lessons, modeling activities, and dance classes. Maria was an excellent student in Cape Verde, and has continued to perform well here in school. She spent a relatively short time in the Cape Verdean Bilingual program, due to her tremendous effort and enthusiasm in her classes. She has great aspirations for the future.

Maria eventually went to live with her paternal grandmother, since the relationship with her step-mother was strained, and she feels that this led to problems for the family. Although she still lives with this grandmother, her mother has recently arrived from Cape Verde and has taken residence in a nearby city. Plans are in the making for Maria to eventually live with her mother, which she wants.

ANNA

Anna was 18 years old at the time of the study. She came to the United States to live with her father and step-mother at age 15. While in Cape Verde she always lived with her paternal grandmother. She knew both of her parents, who

were never married; she has three brothers and one sister in America and three brothers and two sisters in Cape Verde. Anna speaks very lovingly of her grandmother, whom she misses a great deal. Anna says that they communicated very easily, and that her grandmother understood her. Anna speaks about returning to Cape Verde one day, because her grandmother is still living there.

Although she does not have a great deal of restriction in her present home and no conflict, she does not communicate a great deal with her father and his wife.

According to her teacher and guidance counselor, Anna's educational foundation was not very good. She is conscientious about attending school, but her motivation is limited. Anna does hope to graduate from high school.

The Research questions and the study findings are presented in the remainder of this chapter.

Research Question #1

What possible causal/contributing factors are present in the case studies of those students who exhibited suicidal behavior?

1. Parental loss is a significant factor in each of the lives of the students. Two of the subjects experienced the death of their fathers and felt they had never said goodbye. According to the third young lady, whe was taken from her mother when quite young, ostensibly to

visit her father's family; however, she was never returned to her mother and led to believe that her mother had abandoned her.

Diana's early history revealed parental loss, which experts state quite often is in the background of suicidal adolescents. In addition to experiencing the loss of her father, there are unresolved issues surrounding his death because she was not informed directly and sensitively by her family, and she was not allowed to participate in the funeral services. Well-intentioned though they were (trying to protect a very young child from the pain), this loss and its attendant problems have affected Diana considerably. She stated:

> They told me that my father was sick in the hospital; the day he died they told me that they had to find him a way to Portugal, because that's where they have better doctors. It wasn't true. All along he was dead.
>
> I seen with my eyes. I seen my sisters. I don't know why my mother didn't want to tell me. I saw them lking. I was playing with my friends. We were small. I seen my family walking. I seen this girl pass by, and I said,'what's going on? I see them walking with the coffin.' I guess the girl wasn't mature enough. She said, 'your father died,' and she walked away. That's it. I didn't know what to say, what to do. I couldn't cry. I didn't cry. What bothers me most is that I found out just like that; a girl passing by and telling me your father died, like that. There was no one there to hug me and say my father died. (she cries; this counselor hugs her).
>
> Sometimes I can't stop thinking about it. It will always be there. I will always remember this day. And I kept on wondering for the rest of my life, why didn't my mother tell me? and I ask her and she gets mad. That's my mother, when you ask her a question that she doesn't want to answer, she ignores you. That gets me mad even more. Now I just live with it.

When asked how she felt after his death during the interview, Diana said,

> I felt like dying. I wanted to go where he was; I missed him so much. I used to always hurt myself; I used to always be in a corner crying. I felt like he died, and it was my fault because I couldn't help him.

Lidia spoke about her father's dying.

> I wanted to go to Portugal; my father was old. I knew I was not going to see him forever, so I wanted to go with my father. Before he went to Portugal I didn't say goodbye. He took us to my relatives house; when I came back to where he was I didn't find him there. I felt sad because I wanted to say goodbye, and after he died I wanted to say goodbye. (she starts to cry).

Lidia was unable to attend funeral services, because her father died and was buried in Portugal.

Melinda was taken with permission from her mother by her paternal aunts, ostensibly for a visit with her paternal grandparents, who lived on another island.

> They talked to my mother first; they said if they could take me for a few days. My mother said, 'I agree with that. You have a right to have her for a few days; but I want her to live with me.' So I went to their island with them; and after that I never went back to where my mother lived. They loved me. I was the first neice and granddaughter. they were excited and they wanted me to live with them cause all the sons and daughters emigrated and the mother and father were alone, so they wanted somebody for company, and that's the reason why they wanted me to live with them. They kept me for ten years. My father wasn't living there; he went to Portugal. Then after Portugal he was traveling back and forth from the US on the ship.

2. Immigration to the United States for these families meant separation, causing a great deal of trauma in the lives of the young women. Each of the three adolescents had disrupted early lives; in two cases the

disruption was a direct result of the mother's emigration to the US, and in the third case, the father had emigrated to this country and the child was taken from her mother. The families were fragmented, and the girls lived with various caretakers during formative years.

Diana's mother came to U. S. shortly after her father died and she was left in Cape Verde. She stayed with a family friend, while other siblings who also remained in Cape Verde stayed elsewhere. In discussing this at one point Diana said,

> I used to feel scared; my mother wasn't there and that was the time I just lost my father and my mother left. I thought it would be the end of the world, I was so scaired. When I was in that room (bedroom) I used to look at the wall and think where's my mother? Where's my family?

Diana lived with a family friend after her mother departed for the United states. Some of her siblings came to America with her mother, while some remained in Cape Verde. She became ill and was hospitalized while in this home, and an older sister then became her primary caretaker.

Lidia's mother came to the US when she was 10 years old. "I was closer to my father because I didn't remember my mother." Her father traveled and when he went to Senegal, "I stayed with his friend, but I had to be in charge of everyone; the lady came at night to check on us. I had to cook before I went to school, that way I didn't have to cook twice." After her father died, "I was with my

older sister, then she came to America before us, so we had to go to another place to live with my cousin."

Melinda lived the first few years with her mother, and then spent the next ten years, primarily in the care of her paternal grandparents, with her grandmother the principal caretaker; however, during those years her grandmother traveled to Holland, leaving her in the care of her grandfather and a family friend when she did. At the age of 8 years, Melinda's mother, who had been searching for her found her, and she returned to live with her mother. This didn't work out and lasted just a short time, since Melinda missed her grandparents.

> I was 8 yrs old; I didn't know I had a mother. All of a sudden she appeared and she was yelling my name. I looked up and saw a lady I never saw before; it was scaring me. I was carrying water on my head; I ran with that thing on my head. I got all wet. She (mother) started to cry. I was so happy; she brought me mangos. I felt like I knew her so long. I used to go back and forth visiting her. I used to spend the summertime 2 weeks, so that's how I got to know her; and then after I started going to jr. high school I had to live with her. I was 11 or 12. Even though my grandparents used to hit me, every time I go to another place I used to miss them; when I went to visit them at xmas I was crying when I came home; my mother was so mad. I told her I missed my grandparents; so I told her I wanted to go back to my grandma. She was sad; she sent me back. I shouldn't have done that, but I didn't do it on purpose. Then I started visiting her again; we started getting close again.

3. In each case when the girls were later reunited with the parent figure in the United States, there appeared to be no close relationship; each of the girls

experienced rejection, and two were virtually left to fend for themselves.

Diana had this to say about life with Mom after coming to the states:

> She used to always be nice in Cape Verde; she used to always be happy, and if you were talking to her she used to show you that she was hearing you; but now if you are talking to her she don't even care what you're saying; like it don't matter to her. It wasn't like that before. I wish my mother would change; it seems that she don't like me.

Lidia had difficulty reconnecting with her mother when she came to the US at age 16. "My mother wasn't close. I didn't feel the love from my mother, because she was too strict." It was Lidia's opinion that her mother didn't care about her children. "She only cares about her life."

Melinda spoke of coming to live with her father in the US when she was 14.

> In the beginning I had to - it was kind of nice; but all the time he was warning me: don't do this and don't do that, cause if you do i'm going to punish you; every time I did something wrong he would send me to my room; no TV, no telephone; no nothing;in the beginning it was kind of nice; he would take me to get pizza and once to the mall; I used to go to sears with him; he didn't trust me. Every time he would go to pay some bills he would take me with him; every time I did something wrong he would punish me; sometimes I couldn't go out. When I was living with him I wanted to go out with my friends to a birthday party or something; he wouldn't let me go. I never told him a lie so I would be so mad about that; when I'm mad I have an ugly face. I don't mean it. I gave him dirty looks; I don't mean it; he would hit me. my father treats me like he doesn't like me; so that makes me mad. Sometimes I ask why doesn't he like me for what I am? Sometimes I think why did he have to put me here and then abandon me? It makes me sad.

4. It is the perception of all three of these students that at the present time no one in their immediate family who is accessible to them really cares about them; they feel alienated or isolated from family members.

Diana remarked about her family that "my mother and sister, they talk secrets right in front of me." When asked specifically about her relationship with her brothers and sisters, she said, "sometimes they are nice to me, but sometimes, I don't know, they treat me different, like I'm different." Diana's journal entry of March 23, 1991 included this statement: "I wish I had someone in my family, meaning my Mom, brothers and sisters that I could really say that loves me or want to help me. It wasn't my fault." (referring to sexual abuse)

Lidia has expressed hurt feelings when discussing the fact that her mother does not seem to care for her the way she feels a mother should. "My mother doesn't even come to my house; she goes to my sister's house. My house is close to my sister's house; if she goes there she could come to my house."

When asked about her relationship with siblings she replied, "we're not close; they were always fighting in Cape Verde." Lidia expressed a wish that her family members would stop fighting with one another, and she clearly stated that she didn't feel close to anyone in her family.

Melinda feels, as has been cited already, that her father doesn't care about her, and that he has abandoned her both physically and emotionally. For a time she lived with a step-sister after leaving her father's home, but that relationship is extremely fragile and she left that home. She has lived with friends and alone since the living arrangement with her step-sister did not work out. As recently as January 23, 1992 during our last session she expressed to this writer that she didn't want to remain alone in her apartment because of the poor neighborhood plagued by drug activity and housebreaks, but that she had no one to turn to in her family.

5. Communication in the family was poor for these three adolescents. Their responses during the interviews were replete with verbal abuse, expressed hostility, and disparaging content. This was communication between the child and the parent and/or communication between the child and siblings.

Diana is frustrated over her communication with her mother in particular. She responded to one quesion this way: "whenever I try to tell her something she acts like she doesn't hear: when someone is there she acts like she hears me, but when it's her and me she doesn't."

A journal entry in April 1991 read:

> My sister and I got into a fight cuz every where I go she always got to say something bad about me. I never done anything for her to treat me like she does. They were all treating me like I was different.

This researcher's case notes of October 10, 1990 revealed Diana's feelings that she was responsible for the sexual abuse she received because an older sister made negative remarks about her suggesting that this was so. Also, her brother one day accused her of being the cause of the abuse and said, according to Diana, "it was your fault, Diana; you're a girl and you probably went to him and stuff." This researcher's case notes of March 22, 1991 included the following:

> According to a friend of Diana, she (Diana) told her that she couldn't take what was happening at home; mother doesn't speak to her and she is miserable. The other siblings get on her case. Diana told her friend that this time she was going to get a whole lot of medicines and take them, and that this time she would really kill herself.

Lidia described a home situation where there was little if any positive communication. Her older brothers were disciplinarians in the absence of her father, and communicated with her accordingly, demanding respect in her communication with them. There were severe consequences (physical punishment) when she didn't. She was often accused by older brothers of inappropriate behavior with no justification, other than the fact that she would like to visit a friend. "They said we were going to walk the streets." She also described poor communication, if any, with a sister: "One of my sister's doesn't even say hi to me in school." Her guidance counselor's observation of interaction between Lidia and her mother: "There appears to

be some problem, friction with her mother from my observation."

Melinda, while living in her father's house, had limited communication with him and his wife. The verbal contact with her father most often occurred when he gave her orders or expressed dissatisfaction about something. Sometimes there was no communication at all:

"He stopped talking to me in the house because I went to Maria's house. He woke me up at 2 o'clock in the morning to ask me who gave me permission to go out. I told him that I asked my step-mother. He started yelling at me."

She vividly recalled an embarrassing experience when her father came into a local health center and started yelling at her in a crowded waiting room because her appointment was taking too long.

6. All three girls had suffered some type of abuse: physical, sexual and/or emotional abuse. Formal child abuse reports had been filed in two of the cases, and a child abuse report would have been filed in the third case, but due to the age of the adolescent, who opted to live on her own, the report was deemed inappropriate. The caretaker behavior would have warranted formal filing, if a mandated reporter had known of the circumstances prior to her choosing to live with another relative.

Diana was molested by an individual outside of the family. Additionally, at one point during the school year a formal child abuse report was filed with the Department of Social Services, primarily for emotional abuse suffered as a result of treatment by her family members, who appeared to view her as having violated cultural norms by taking family matters to outsiders (the school). It appeared that feelings of alienation at home, in part, precipitated suicidal threats that were reported by friends who had observed the home treatment.

Although she was almost 18 years old at the time of one incident of physical abuse, Lidia was beaten by two older brothers for answering back, (which they considered disrespectful) when she was questioned by them about her planned social activities. The school filed a Child Abuse report when she appeared in class with a black eye and bruises. The family relations became further strained as a result of the outside intervention by the Department of Social Services. According to Lidia and school personnel, the mother felt that the brother's actions were justified.

This young lady also suffered physical abuse in her relationship with her boyfriend, a long term relationship.

Melinda spoke of abuse suffered while living with her grandparents in Cape Verde. They punished her by hitting her with wood, belts and rope. At other times she was disciplined by having to miss a meal. She had this to say

about their treatment of her: "sometimes I remember those things, and it hurts so much."

According to Melinda, her father physically and emotionally abused her and neglected her basic needs for shelter in this country.

7. All had trust issues, having virtually no one whom they trusted to be there for them, and they stated this quite emphatically on many occasions.

Diana frequently stated that no one in her family likes her or cares about her. She felt abandoned by them because they were not supportive of her during the crisis of sexual assault. Further betrayal was felt in that she was blamed by some family members for causing the abuse, even though the perpetrator was a middle-aged man. This is clearly Diana's perception and it is not necessarily reflective of the way that her family actually feels about her; however, it is this perception that has motivated much of her self-destructive behavior.

When Lidia discussed her overdose after she thought her boyfriend was going to leave her, she had this to say: "I thought if we have to break up and I have to be by myself, I would rather kill myself because at that time it was only him that I trusted. I don't have friends that I can trust."

Referring to her father and step-mother, Melinda stated, "I don't trust them; they never trusted me. At a point of desperation while still in her father's home,

Melinda was frightened after her step-mother suggested she find another place to live; according to her step-mother, her very presence in the home was more than her father could handle. Melinda stated, "I said what if I was sleeping and he tried to come to my room and kill me."

If we can't trust the very individuals who brought us into the world, it is not difficult to imagine that trust in others would be extremely difficult, if not impossible. Even with friends, Melinda could not trust that they were really genuine with her. "Sometimes I think, do they like me or maybe they're just using me."

8. Each of the girls lived in closed family systems both in Cape Verde and in the US. Once they arrived in the United States they were caught in the culture clash of trying to exist in two worlds; the strange American society with a more liberal experience for American youth, and a focus on independence and the individual. This is very foreign to the traditional Cape Verdean home that reflects a cooperative, rather than competitive/individual culture, with an emphasis on family and the cultural community. This family system seeks to restrict the adolescent's (especially females) involvement in this new world, which immigrant parents and older siblings consider to be a society that encourages an

independent, and sometimes defiant lifestyle which frequently fosters societal ills of alcohol, drugs, and sex. Culture conflicts regarding strict mobility for females and subordinate treatment from male relatives was significant and vehemently challenged in each of these cases.

When asked about special problems facing Cape Verdean youth, Diana remarked, "you want to go out like your friends, but you can't because your parents are strict, not like your friends' parents. Your mothers and fathers don't let you go to parties and movies." She also had strong words about male/female differences that were unacceptable to her once she acquired more Americanized views.

> Girls do the work around the house, not boys; I look at it as if girls are slaves. Girls are supposed to stay home; they can't go out; if you have an older brother they can't see you talking to a guy even if you're 17 or 18.

When this writer asked her if brothers feel in charge of sisters at times she replied, "not at times; all the time."

Lidia's experiences with physical abuse in the home were due to her older brothers attempts at restricting her social activities, and she openly defied them. During the interview she stated, "In America teenagers can go out; in Cape Verde you can't. When the parents cme here they keep the rules from Cape Verde and when you see other kids go out and you can't go out you, you feel sad. Sometimes you could

go out with your older brother." On the occasion that she was beaten by two older brothers for answering them disrespectfully, Lidia was just as upset with her mother who felt the brothers were justified in hitting her. She was nearly 18 at the time.

Male dominance in her family was a serious issue for Lidia. She spoke of an occasion when she was 18 and had plans to go to a party with friends.

> Once I couldn't go to a party because my brother wanted me to go home with him to clean his house. He said his wife was sick and she couldn't watch the kids, but when I got there she was watching TV and wasn't that sick.

Lidia said that although her older brothers didn't live in her house, they set the rules for the house, since they felt they had to take their deceased father's place.

When this researcher asked Melinda about her ability to socialize and curfews, she had this to say:

> Me go out by myself? Are you kidding? Every time I go out I have to go out with them (parents). They treat boys different; they think that girls should be something different. You cannot do this, you cannot, like 18th or 17th century; the way they treat women.

10. All three students felt they were a burden to the family and/or responsilble for the problems in the home.

Diana felt that she was responsible for a lot of the problems in her home. "It's like everything is my fault; and my mother is always saying there is no money for bills, and it's my fault." When questioned how she could be responsible if there was no money for bills, she said, "I

don't know, but it is all because of me." She added that she felt that she was responsible for all the bad things that happened. Diana also told this researcher on more than one occasion, "it would be better if I wasn't here."

Lidia felt that the reason she had to leave school at age 16 years was because her mother couldn't supply her needs.

> I started going to school and then I stopped going to school because my mother wasn't buying clothes for me to go to school. She said I had to work to buy my own. I quit school, then Mr. Barboza, where I worked for the summer job asked me if I wanted to go back to school. I said yes.

When asked what her mother said, Lidia replied, "she didn't care," but added that she still had to buy her own clothes and things when she returned to school, and shortly thereafter she left home and went on her own.

Melinda told this researcher that her father made her feel that her presence in the home was responsible for problems in his marriage. Feelings of being a burden also surfaced when she discovered that the reason her father 'threw her out' was to make room for someone who could pay room and board. Whether this in fact was true is not at issue; the critical fact is that this is Melinda's perception; she considered herself a burden and worth nothing as evidenced by her comment on this matter made during a session on January 23, 1992: "When you're father does something like that you feel like you're nothing. I sometimes wonder why I'm living."

11. In all three cases the young women have expressed feelings of 'I don't know where I'm going, where I'm welcome or where I belong. Two of the young ladies are presently on their own, living in apartments, and receiving public assistance, while trying to complete high school. Each has had several changes in residence since the 1990-1991 academic year began. The third young lady no longer lives with her mother, and has had two changes in residence since the study began. She now resides with an older sister, after a brief, difficult stay with another older sister.
12. Peer relations for all three girls are problematic; and very much an expressed concern for two. The one young lady who appears to have limited close friendships has been involved in physical altercations with peers, suggesting a possible problem in her peer relations. Loner behavior appeared to be evident in each of these cases.

Diana remarked during the interview that she liked to spend time alone. "I used to always want to be with my friends before, but I changed. I spend a lot of time in my room." Although both her teacher and guidance counselor felt that she had friends, the loner behavior and a physical fight with another female student indicate possible problems

in this area. The loner behavior in particular, which is a change in her behavior, is very much suggestive of behavior in suicidal adolescents.

Lidia expressed sadness about her lack of a best friend and trusting close friends. "In school some friends are with me when their best friend is absent, but when their best friend is here they don't bother with me." When asked if she had a best friend, Lidia responded, "no." She does have friends whom she only sees in school, but Lidia does not feel that she has friends whom she can trust. After school she spends a great deal of time alone at home studying or reading.

Melinda's peer relations appear to be very fragile. Her teacher remarked that :

> she has a limited number of kids that she can approach; but even then she doesn't open up quite a bit to them. They are very shallow relationships from what I can see. She's very withdrawn. I'm trying to think of a close friend of hers, and I don't seem to come up with one that I can say, yes, she's very close to this particular kid. She tends to be very blunt with her classmates; she tends to blow up very quickly, does not tolerate much of anything; she doesn't take criticism very well. She does not take kindly to kidding around; she would blow things out of proportion. And that happened to be with a majority of the kids. It's hard to say that with 20-27 kids that you wouldn't find a few kids that you can get along with; she doesn't seem to want to participate in a friendship, she appears to have some kind of problem.

Melinda once remarked, "sometimes I see my friends with other friends and they don't talk to me. I think what's with me."

Melinda stated that she liked to "spend time alone in my room. I don't care about going out no more, cause I'm getting used to staying in the house. As long as I have TV you can do anything you want with me; I don't care. As long as I have TV and music I can stay there all day."

12a. Peer pressure must not be overlooked in terms of the suicidal behavior of each of these young ladies. Peer pressure in different forms and to a different degree was evident in all of the cases. It was most evident that Diana succumbed to peer pressure to a much greater degree, and demonstrated her desire to be very much like her peers in her drinking, drug use, and acceptance of dating and sexual behavior of her more Americanized peers. To some extent the peer pressure around socializing caused conflicts at home for Lidia and Melinda, as well as Diana. They, too, wanted to go out and be with their peers as they were urged to do on many occasions; however, it does not appear to have influenced them with regard to substance use, and the former two young ladies made specific statements indicating that they considered such behavior unacceptable.

13. Culture shock and feelings of isolation from their peers in the entire school community related to

racial/ethnic/linguistic differences were evident in these cases, and may have exacerbated the already low self-esteem of the young ladies. In Cape Verde they had not experienced the prejudice and isolation from their peers that was directly related to their ethnic and linguistic differences.

Diana's observations about racial/ethnic/linguistic differences were revealing. "Sometimes people put Cape Verdeans down, especially Portuguese people. In Cape Verde everybody treats you nice; like your equal. I think I'm equal; I'm not better than anyone else, and no one is better than me." In general Diana felt that being here in the US is:

> It's weird. Like in Cape Verde people look at you like you're equal, but here it's not like that. They look at you like you're different. At first people make fun of you. They call you 'greenhorn' (derrogatory name for immigrant). If you just came from Cape Verde they say you come from the banana boat. It hurts. And people always want you to speak English. If you're talking Crioulo they want you to speak English and they put you down. They say don't talk this language here; this is America. They don't even consider our language a real language, and I wanna know, if it's not a real language, how come we can speak it? Isn't that what a language is? You can't even take classes in Crioulo, and they have every other language class. How come our language isn't good enough? That makes me so mad. And I think it's terrible that Crioulo kids born here can't even talk to us; maybe if they had classes theycould.

In discussing interaction with Cape Verdean-American students born in the US she had this to say.

> Sometimes they act like they're not Cape Verdean; they act like if you just came from Cape Verde you're

somebody that's down; they treat you different; not all the time. Sometimes they treat you right; they help you, but that don't happen all the time. One of my friends, he just came from Cape Verde and sometimes he tries to talk with Cape Verdean (American) people that he knows around school, and they pretend that they don't understand him, and they are Cape Verdean just like he is, but he just came from Cape Verde. They look at you like you're a greenhorn (derrogatory name for immigrant) or something.

Melinda expressed a dislike for some students.

I dislike those kids that think that they speak English better than us. When they hear us speaking English they make fun of us and that hurts. I don't like that, and they ignore you. They pretend that they are better than you. I don't like that.

When speaking about Cape Verdean-American students (those born in the US), she had this to say.

I don't know them. They don't talk to us, so we don't talk to them. Us Cape Verdeans from the old country, we have our own group, and the Cape Verdean kids born here have their own. We don't hang out with them and they don't hang out with us. But if we were in the Cape Verde Islands, we would do anything to be with them, to help them, to teach them our language and everything. But they don't care; they don't help you unless you ask them. I don't blame them; that's how their parents raised them. Maybe they are ashamed.

Melinda always seems to try to use English, even when she doesn't understand, and when this researcher would attempt to explain certain questions in **Crioulo** to be sure she understood the question, she would abruptly say, "Speak English, I can understand you," even when there was no doubt that she needed the native language clarification. This suggested a real sensitivity to the issue of her native language and the desire to acquire and use English.

Lidia spoke about how she felt when in some classes with students in the regular education program.

> We have some classes with them, but we stay quiet. Sometimes they talk to us and sometimes they don't. We sometimes feel uncomfortable. We don't like to talk because we think the other kids are gonna laugh."

She is very self-conscious about her English fluency. "Sometimes I don't understand the English. To get a better job I need to speak better English."

14. For each of these young women, a relationship with a male appears to be critically important. Although this is not unlike the priority of a great many adolescent women, it appears that for them it is either essential for their survival or critically important to have male attention.

Diana's teacher commented that "she really needs a lot of attention from the boys; almost to the extreme..." Another source suggested that the precipitating event in Diana's suicidal attempt was rejection from a boy (although this researcher questions this, it could certainly have been a contributing factor).

Lidia's overdose was precipitated by the threat of losing her boyfriend. She felt that she would be alone "with no one whom she could trust" if he left her. She said she would rather die.

Melinda told this researcher that "I think about boys all the time. It makes me sad that I don't find a guy that I like or a guy that likes me. I would like to have a good

guy to spend my life with, to marry till death tear us apart."

15. Low self-esteem was a factor in each of these cases.

Diana talked about wanting to be a doctor with this researcher, but added at one point, "but I'm not going to make it." Other indicators of low self-esteem include her view of her family's feelings toward her which were negative.

There are many indicators of Lidia's self-esteem. She admittedly has no self-confidence, and when asked about her confidence level she replied: "Sometimes I want to do something, but it's always something I can't do. I don't try enough. I finish schoolwork; sometimes I think it's right, but it's not. " Lidia feels that she has below average intelligence, and stated, I'm not smart."

Her teacher had this to say, "Her self-esteem is very low. She never thinks she's good enough to get a good grade, and when she does get a good grade, she would always question, 'how did I do that?' I recommended her for the banking program. She didn't feel that she could do it."

There were many indicators of Melinda's low self-esteem. Although she is quite attractive, she stated to this researcher:

> I think if I had money I'd have surgery." When asked what kind of surgery, she said, "my face" (she laughs). I feel like nobody likes me because I'm not beautiful, because nowadays people are looking for beautiful people. Sometimes I think when I look in the

> mirror I see this ugly face; no guy's gonna be interested in me; sometimes I get sad.

Her teacher felt that her self-esteem was low from his observations of Melinda in the classroom.

During her interview Melinda remarked, "Every time I do something I think I did it wrong. I don't expect things to come out right, but they do come out right."

16. The three young women who exhibited suicidal behavior were characterized as having mood swings and emotionally unstable. Depression and feelings of hopelessness, which are frequently descriptors of suicidal adolescents, were present in these young women.

Diana's guidance counselor remarked that she had very obvious mood swings.

> I think Diana's on a roller coaster, emotionally. She has highs and lows. When Diana's wonderful she's beaming, she's enthusiastic, she's on top of the world; when she is low, there's a dark cloud, she has a serious face, she's inward, she looks to the ground, there's no expression or a very sad expression...she's very much isolated and into herself, and you can visibly see that she is withdrawing into her body, and when she's high, she's radiant; she's sunshine down the corridor.

Her teacher remarked, "She does have mood swings, and during that period she can go from high to low. They happen right in front of me and I don't know why. Nothing happens; nobody says anything to her; she's sitting there and she's laughing one minute, and the next minute she's as low as can be."

Other remarks relative to her emotional tone were significant. Her guidance counselor stated,

> I think she views sometimes that things are so out of control in her life and she's so helpless, and that she can't do anything about things and that there's no one there to help her, that she feels that if she kills herself it will end, because she just can't take it anymore. She often says that to me, 'I just can't take it anymore.' There are times she's in such despair that she doesn't think and she'll do things like take pills or something like that.. she feels that's her only way out.

Diana's own remarks are suggestive of her depression/despair:

"I'm always worried; most of my friends are happy. I'm always laughing and I'm happy, but really i'm hiding what's inside of me. I used to always think about killing myself."

This researcher has experienced the depression and sadness of Lidia. Her affect often reflected inner pain. Her teacher noted her depression and referred her to this therapist.

> When she has problems she withdraws and tends to have tears. That is one of the reasons I referred her to your office. She would be in class with tears and there were days I wouldn't know what to expect from her; sometimes she would be in class with tears and a sad face and not participate.

This same teacher felt she was rather unstable emotionally and had mood swings, noting that he would find her feeling fine in one class, but radically different during a later class. Lidia told this researcher that most of the time she feels sad.

Melinda's teacher spoke of obvious mood swings:

> she can blow up at someone right after she has just laughed at another doing the same thing. She seems unstable, especially when she blows up when you least expect it. She tends to be emotional.

Melinda, herself, spoke about her mood swings.

> Sometimes I get in a bad mood and I wonder how come I'm in a bad mood and nothing's happened. How come I'm sad? Then the good mood comes and I'm so happy, but I don't see no reason to be happy; I don't know."

She also discussed her quick temper.

"I have this temper; I gotta get over it. Every time they (classmates) do something I jump quick. I gotta get over it, because I don't like it either; it came from my father."

Melinda often expressed that she couldn't understand why her father treated her so poorly and that she wished things could be different between them, but her despair was obvious when she stated that "he'll never change" (referring to his treatment of her).

17. Each of the young women appeared to have impulsively considered suicide in response to overwhelming feelings of rejection/abandonment.

Diana, according to her account, angrily ingested pills on the night of her overdose in response to feelings of rejection and emotional abandonment by her mother. Another source questions whether it was the rejection from a boy whom she liked, while yet another source within the family stated that the precipitant was her mother's insistance that she couldn't go out this Friday evening. Whatever the

cause, Diana informed this researcher that she went angrily to her room and saw the pills; when her girlfriend left the room to go to the bathroom, she grabbed the bottle of pills and swallowed an undetermined number.

Lidia took pills impulsively at a restroom during a dance that she was attending with her boyfriend. This action was taken after he paid a great deal of attention to another young lady, and she feared he would leave her.

During Melinda's early years with physically abusive grandparents, her suicidal ideation appeared to be the direct result of corporal punishment. To some extent this was true in her interactions at times with her father; it is this researcher's opinion, however, that the physical/verbal abuse Melinda experienced could have been interpreted by her as rejection by all of these caretakers. She certainly felt emotional abandonment by her father.

18. Drug and alcohol abuse was noted in only one case history.

The young lady in question stated that :

> Before I used to go out with some friends and smoke weed a lot and drink. I used to always want to drink. Now I don't even want to see weed in front of me. I just wanted to stop and I did."

19. Poor school performance is often noted in cases of adolescent suicide. In all of the cases, erratic or poor performance was noted.

Diana's performance in school was erratic and her guidance counselor expressed it this way:

> I think she's inconsistent; when she, when things are going well her attendance is superb; and she can do her work. She definitely wants to do well and she is enthusiastic about school; but when thigs go awry, she is not able to meet her responsibilities. To tell you the truth, I am amazed that she passed every one of her classes and that knocks me out because she's been so up and down all year long so many times that she's not been able to do some of her work because of having to see me or having to see you, or just not being able to function; to be able to pass all of her classes in the end, I think is remarkable.

Diana stated that she liked school, but added this: "with all the problems I have I can't concentrate; I never want to do work."

Melinda's teacher stated,

> there are times when she works very hard, and there are times when she slacks off, and I have to get on her case to get back to work. For a while there she was taking days off. I had to approach her on that. She does work hard for the most part to get good grades. She comes after school for help and she always strives to do better in her English.

Lidia's teacher offered this view of her school performance:

> When she has problems she withdraws and tends to have tears, and there are days when I wouldn't know what to expect from her. Sometimes she would be in class with a sad face and not participate. She had some problems that caused her to be absent. When she is happy she participates quite a bit.

This researcher has been involved with all three students as a therapist; it is remarkable that all of them have been able to attend school and achieve as well as they have been able to do, given the extreme adversity that they have faced, sometimes on a daily basis. It is a tribute to them and truly reflective of the high value that they each

place on getting an education in this country. This author finds it amazing that they have not dropped out of school either literally or figuratively.

20. A sexualized lifestyle was very evident in one case.

The family complained that the young lady would sneak out of the house in the middle of the night and meet a boyfriend who was not approved of by the mother. Sexual activity was definitely involved, and pregnancy became an issue. One teacher reported that this student's reputation was attacked by peers who alluded to promiscuous behavior, and consequently a fight ensued at school. One of the students is pregnant at this time, and one student has had a child with a young man with whom she has had a long term relationship. Sources in this study questioned sexual activity of two of the young women and felt that in both cases it was definitely an indicator of desperately needed attention.

In light of the stigma of pregnancy in single Cape Verdean women, it is not surprising that depression and suicidal ideation became problematic for the young women who became pregnant. I would like to interject at this point that a fourth student who was originally a study subject was eventually eliminated. She became extremely depressed and suicidal and made a suicide attempt by ingesting a large quantity of pills because she had become pregnant and

overwhelmed with her circumstances. She was living with relatives in this country and preferred to face death than the shame and rejection she would surely confront once they learned of her plight (This was her opinion of what she would face). She clearly was too fragile to expose to the demands of the study.

Research Question #2.

What are the precipitating events in these cases of suicidal behavior?

DIANA

Diana's suicide attempt occurred one Friday evening during the Fall of 1990. There was a great deal of tension in the family at that time, since the two family residence that they occupied was also the residence of the landlord and his family, and it had been alleged by Diana that the middle-aged husband/landlord, had sexually abused her. This resulted in police action and formal charges, which clearly strained the relationship between the two families. This particular evening, according to Diana, the wife had ventured upstairs to her apartment and eventually began screaming at Diana about her accusations regarding her husband. Diana stated that she became very upset by the woman's behavior toward her, but even more dismayed and upset by her mother's seemingly passive attitude, rather

than a protective stance to support her daughter. It is significant to interject that culturally speaking, it might not be unusual for a tenant to defer somewhat to a landlord. However, Diana felt that the entire family was really angry that the matter had not remained within the family to handle, which is culturally understood. However, the perception of this adolescent was that she stood alone in this matter, with no support/empathy from her family. This perception may not reflect the feelings of all of the family members; nevertheless, this perception spawned her feelings of abandonment and isolation.

> the night I took them pills..it was me and Nancy. I was going upstairs to my house, and I seen that guy that lives downstairs; I got so upset; I told my mother, "I don't want to stay here anymore; I want us to move". Then my mother started getting mad. Then the lady came upstairs, the one that lives downstairs and said, "how come you don't go downstairs to my house anymore?" I didn't want to even talk to her; my mother said, "she just doesn't want to go there anymore." and I said, "because your husband tries to touch me whenever he sees me." She started swearing at me and yelling at me, and instead of my mother saying something my mother was just sitting there and that got me more mad; instead of my mother saying, leave; my daughter's getting upset or something, she just sat there, and I got real upset. I said, 'damn, if my own mother can't say anything, who can, then.' Then Nancy went into the bathroom, and I saw these pills and I took them.

Diana's impulsive act was not witnessed by her friend, but she soon learned what Diana had done and informed her mother. The self-poisoning resulted in a one-day stay at the hospital.

Clearly this preciptating incident was the straw that broke the camel's back and only the culminating ingredient in the complex life journey that resulted in the wish to die.

It is significant to add that other information sources revealed to this researcher that they felt the reason for the ingestion of pills was possibly related to a frustrated relationship with a boy, and/or her mother not allowing her to go out that evening as she (Diana) had wished. This researcher's experiences with this student suggest that the latter two possibilities could in fact have contributed to her impulsive decision, but careful analysis of her many counseling sessions and her journal entries which she, provided suggest that her belief that she had been emotionally abandoned by her family was the precipitating event. It is significant to interject that this piece of data collection points out the significance of triangulation, since Diana never mentioned her mother not wanting her to go out that evening, and it is highly probable that she was upset about not being allowed to go out; the other sources, certainly the family, seemed unaware of how totally abandoned Diana felt. subsequent suicidal feelings and threats seemed consistent with her perceptions of her family status. Her Guidance Counselor, with whom she also confided, concurred with this researcher's findings.

Partial journal entries of March 1991 read:

> I wish I had some one in my family, meaning my Mom, brothers and sisters I could really say that loves me or wanted to help me, like you and Mrs. ... (guidance counselor). They are treating me like I was different; everything is my fault. I hate that. I wished my family liked me the way I like them.

Lidia

Lidia's whole world revolved around Jose. The Saturday evening that she took an undetermined number of pills was fraught with tension between them as they socialized separately at a local college Crioulo dance. Jose's flirting and attending to other females was extremely upsetting to Lidia, who was expecting their child and saw Jose as her life partner.

> It was a Friday; Jose and I were fighting at a party at SMU. He was dancing with someone else and ignoring me. I took the pills in the bathroom at SMU. Jose took me to the doctor's the next day; I called the doctor's office that night and the answering service was on.

I asked Lidia, "what were you thinking when you took the pills?" Her reply was: "to kill myself. I thought if we have to break up and I have to be by myself I would rather kill myself because at that time it was only him that I trusted."

In this researcher's opinion, Lidia, like Diana, had reached the point of no return, not merely due to the specter of Jose leaving her, but this was reminiscent of previous abandonment and would have been intolerable.

Melinda

Although Melinda did not make a direct, overt attempt on her life at the time of referral by one of her friends, she was depressed and suicidal, and this researcher was concerned, particularly because she clearly expressed to this researcher that she wanted to die on many occasions in her past and had made a couple of serious cries for help.

On the occasions that Melinda did exhibit suicidal behavior it was generally reactionary in nature and precipitated by her father's physical/emotional abuse.

> My father treats me like he doesn't like me; so that makes me mad; sometimes I ask 'why doesn't he like me for what I am?' One day my father was driving me crazy; he went out and left me with Anna (younger half-sister). I wanted to take something to die cause I was sick of him yelling at me for no reason, so I was looking for something like pills or poison to take to die, but I didn't find any. One day he hit me in front of people; I was so mad I threw myself down the stairway from the second floor to the first floor. I was so frustrated I wanted to end myself.

When asked her what she meant by 'wanting to end herself' she replied that she meant that she wanted to kill herself.

She went on to say, "I used to be so scared of him; the way he treated me; the way he talked to me. He said, 'one of these days...I'm gonna...I hate you; I'm going to do something to you. I don't care if I go to jail.' I don't know why he does those things."

Melinda described her father's reaction to her when he asked her to leave their house, following a period of time when they weren't talking with each other:

> My brother called me and invited me to go to his house for the summer so that we could get to know each other better because I met him here. Me and my father wasn't talking so I told my brother to ask my father. He said, "oh yeah; come and pick her up, and try to find a job for her there so she won't bother you." My brother came; we were ready to go; all of a sudden he changed his mind and said, "she's not going anywhere. She's gonna stay here." I was shocked. I felt sad; I went to my room and cried. A day later I went downstairs to get my clothes in the laundry, and when I came back he was mad; he grabbed me by my back and started pushing me and said, "get out of my house; I don't want to see you anymore;" I said, "wait I don't have any place to go." He didn't listen; he threw me out. Then I started crying. I sat down in the corridor outside the apartment. I asked him if I could get my things. He let me pack all my things and he went out. My stepmother said, "wait; you aren't going anywhere." When my father came home I was there, and he asked my stepmother, "what is she doing here? didn't I throw her out?" So I called my stepsister, and she agreed for me to come and live there. I stayed there for a few months. Sometimes I think, 'why did he have to put me here and then abandon me?' it makes me sad.

When asked about her childhood in Cape Verde while living with her paternal grandparents, Melinda had this to say:

> My childhood was kind of abusing (abusive). I don't blame them cause they didn't know what they were doing. They don't have education; they never went to school; they don't read books; they don't know their tempers. Everytime I would do something wrong they would hit me with rope, belts and wood; they would do things that they should not be doing; but I don't blame them for that, but everytime they would hit me, I would get so mad; I would go outside and climb up on the roof and try to fall down. I was thinking everything; everyone was making fun of me and I would be so embarrassed and stuff that I wanted to die rather then be treated like this.

Melinda appeared to feel that she never was completely loved and accepted by those significant others who were the primary caretakers in her life. Her foundation, to say the least, was extremely lacking in the love and acceptance that young people need to feel secure.

Research Question #3

Are there any commonalities in the causal/contributing factors in each of the cases studied?

1. Parental loss is a significant factor in each of the lives of the students. Two of the subjects experienced the death of their fathers and felt they had never said goodbye. According to the third young lady, whe was taken from her mother when quite young, ostensibly to visit her father's family; however, she was never returned to her mother and was led to believe that her mother had abandoned her.
2. Immigration to the United States for these families meant separation, causing a great deal of trauma in the lives of the young women.
3. Each of the three adolescents had disrupted early lives and lived with various caretakers.
4. In each case when the girls were later reunited with the parent figure in the United States, there appeared to be no close relationship; each of the girls

experienced rejection, and two were virtually left to fend for themselves.

5. It was the perception of all three of these students that at the present time no one in their immediate family who was accessible to them really cared about them.

6. Communication in the family was poor for these three adolescents. Their reports were replete with verbal abuse, expressed hostility, and disparaging content. This was communication between the child and the parent and/or communication between the child and siblings.

7. All three girls had suffered some type of abuse: physical, sexual and/or emotional abuse. Formal child abuse reports had been filed in two of the cases, and a child abuse report would have been filed in the third case, but due to the age of the adolescent, who opted to live on her own, the report was deemed inappropriate. The caretaker behavior would have warranted formal filing, if a mandated reporter had known of the circumstances prior to her choosing to live with another relative.

8. All had trust issues, having virtually no one whom they trusted to be there for them, and they stated this quite emphatically on many occasions.

9. Each of the girls lived in closed family systems both in Cape Verde and in the US. Once they arrived in the

United States they were caught in the culture clash of trying to exist in two worlds, the strange American society with a more liberal experience for American youth, and the traditional home that sought to restrict their dalliance with this new world order, which the immigrant parents and older siblings considered to be a decadent, defiant lifestyle.

10. Culture conflicts regarding strict mobility for females and subordinate treatment from male relatives was significant in each of these cases.
11. Two of the young ladies are presently on their own, living in apartments, and receiving public assistance, while trying to complete high school. Each has had several changes in residence since the 1990-1991 academic year began, and at one time lived together. The third young lady no longer lives with her mother, and has had two changes in residence since the study began. She now resides with an older sister, after a brief, difficult stay with another older sister.
12. Peer relations for all three girls are problematic, and very much an expressed concern for two. The one young lady who appears to have limited close friendships has been involved in physical altercations with peers, suggesting a possible problem in her peer relations.
13. For each of these young women, a relationship with a male appears to be critically important. Although this

is not unlike the priority of a great many adolescent women, it appears that for them it is either essential for their survival or critically important to have male attention.

14. Low self-esteem was a factor in each of these cases.
15. The three young women who exhibited suicidal behavior were characterized as having mood swings and emotionally unstable.
16. Each of the young women appeared to have impulsively considered suicide in reaction to overwhelming feelings of rejection/abandonment.

During Melinda's early years with physically abusive grandparents, her suicidal behavior appeared to be the direct result of corporal punishment. To some extent this was true in her interactions at times with her father; however, it could be considered that the physical/verbal abuse that she experienced with these caretakers was interpreted as rejection. Two of the students made actual attempts by ingesting pills of some sort and the third, during one period of suicidal ideation, looked for pills to take.

Research Question #4

What differences are noted when a comparison is made between the group of students that has exhibited suicidal behavior and the group that has not exhibited this behavior?

1. None of the three students who were in the comparison group experienced painful parental loss, abandonment issues, and unresolved death related issues that were part of the histories of the three students who had exhibited suicidal behavior.
2. All of the students in the comparison group experienced their early lives in Cape Verde living with primary caretakers whom they described as very loving, and they openly stated how very much they loved these parent figures.

Throughout the interview Maria spoke of how much she loved her mother. She also expressed much appreciation for how she was raised. "She's (mother) really great. She would try to make me the best that I could be because she knows I can do a lot of things. She's smart; she can do any kind of thing."

She commented on her early relationship with her father prior to his emigrating to the US. "Before I came (to the US) I was really close to my father; he used to say that I was the most beautiful kid he had ever seen; that I was the only thing in his life." Although the relationship with her father changed somewhat when she came to the US, it never reached a level of damaging proportions; she did, however, find that she had to share his love and attention with a step-mother and step-sister, which was very unlike

the adoration and undivided attention she received from him in Cape Verde.

Anna, lived with her paternal grandmother in Cape Verde, but certainly knew her parents and had a relationship with them. She described her childhood as a good one and spoke with much love and affection for her grandmother. When asked how she liked living in America during the interview, she responded, "My grandmother is living in Cape Verde and she's the person I love the most, so I don't like being here." Anna lives with her father and step-mother in the US, and expressed no problems at all in that household. She knew her mother, but never really lived with her; however, expressed no problems related to this fact.

Jose lived with his mother in Cape Verde and expressed love and admiration for her. He stated that living in America was difficult because "I don't have my mother here." His mother frequently occupies his thoughts. "Sometimes I think a lot about my mother in Cape Verde." He spoke of sending what money he could from his part-time job to his mother, and spoke of his most important wish, "I'd bring my mother to this country." Jose's relationship with his Dad is positive.

3. Each of the students in the comparison group lived with one primary caretaker in Cape Verde. Unlike their peers there appeared to be a lot of love and consistency in their critical foundation years.

4. The students who had not expressed suicidal behavior did not experience any major difficulties with the parent they came to live with in the US, unlike their less fortunate counterparts.

Both Jose and Anna remain in the same household they originally came to with their biological fathers. Maria did eventually leave her father's home to live with her paternal grandmother because her step-mother had problems with her in the house. However, her father still is very involved with and responsible for his daughter. Each of these students feel very secure in their present lives and feel they have access to their family members, which is not the case with the three young ladies who feel uncared for by their families.

5. Communication with primary caretakers for these three young people in the comparison group was extremely positive.

Maria had this to say about communication with her mother: "My mother is very straight with me. Everything she has to tell me she explains to me, and she asks me how I feel about it. Maria further stated that when she has a problem, "I try to resolve it myself, or I talk to my mother."

Anna clearly felt the communication with her grandmother was good. "We talked a lot about a lot of things. She understood me. We got along very well." She

indicated to her teacher that she could talk to her father, "I (teacher) remember her telling me that they talk, and if she has something to say to him, she can say it."

Jose stated that "I was very close to my mother. We talked a lot." He is able to communicate with his father, "my father is talking with me a lot."

6. The students in the second group did not have problems being trusted, nor did they appear to lack trust in others.

"My parents let me do things because they trust me," said Maria during the interview.

Anna indicated that her father and step-mother let her go out and do most things that she wanted, indicating that trust did not seem to be an issue in this home.

Jose is a male. That may in fact affect this particular issue. His father allows him to go out with friends, but does expect him to come in at the time specified. He allows him to keep the money he earns. He feels his father respects his privacy.

7. There were no abuse issues in this latter group.

8. The second group of students did not come from families that had very rigid male/female role expectations, nor did the families appear to subscribe totally to some typical Cape Verdean traditions.

Maria was trusted by her parents and allowed to go out with friends, and she was the youngest student in the study.

"If I want to go out with my friends, I'll tell them where I'm going, because I really don't lie to them; they're great. If they don't want me to do something or go somewhere they will tell mey why; they tell me the reasons and what can happen."

Anna, like Maria could go out and do more or less what she wanted. Her father and step-mother approve of and like her fiance. They have never restricted her activities.

Jose was raised to be helpful in the house and continues this behavior in the US. "I clean the floor every day; I pass the vacuum cleaner." His teacher offered this statement on the subject:

> I remember him telling the bilingual aide that he ironed his own clothes. She appeared to be kind of surprised. A lot of boys in this culture would not admit to ironing their own clothes or cooking their own food. He was rather proud of it. He said, "I iron my own clothes, and I cook."

9a. Peer relations seem to be stable and good with this group of students.

Both Maria's teacher and guidance counselor characterized her peer relations as excellent.

> She makes friends very quickly. She came in late (in the school year), and right away when I introduced her to the class she smiled her infectious smile and began to approach the students. She didn't wait for them to approach her. She talked to the boys and girls and had no problems with either group; she fit right in. All the kids liked her.

Anna, by choice, according to her teacher, "has a lot of friends in the classroom, but superficial friends. She

has one very close friend. She comforts other people and is very supportive."

Jose, according to the teacher, "He has quite a few friends in class. He's one of those guys that all the kids like. He's a big buddy to the younger kids; gets along with the freshmen and gets along with his own age group. The girls like him."

9b. The comparison group students had excellent peer relations, but had no difficulty in resisting negative peer pressure. Each had very strong feelings about substance use and other questionable behaviors in their friends that they chose not to be a part of.

Maria had this to say, "People try to force you into a lot of things; you have to be strong and try to say, 'no I don't want to do it.' You have to be really strong and find the right people to be friends with."

Jose was quite emphatic that he was very happy with his current group of friends "because they don't drink and use drugs." He stated that other associates did like to go to barrooms, but he did not approve of this behavior.

According to Anna's teacher, she was never afraid to tell her peers when they were inappropriate in their behavior and discussed it in class. She was also described as being friendly but not in any way dependent on peer approval.

10. Self-esteem and self-confidence in this group appeared to be good.

Maria's teacher remarked that "she is very confident." She attributs her self-confidence and high self-esteem to the way her mother brought her up: "My mother grew me this way. She always showed me that there's a big world out there and I can do whatever I want to do. Before I came here she said, 'Maria, keep on doing what you're doing here. I know you can make it."

Anna expressed that she could handle most of her problems. Her teacher agreed. "She appears to be one of those supportive people, but she can handle her own problems."

Anna herself stated "I feel good about myself." She stated to this researcher that she could handle most things that came her way, and that she had a lot of self-confidence. It was this writer's impression that she was a very self-assured young lady.

According to his teacher, "Jose seems to be a kid that is self-assured. I think he's got pretty good self-esteem." Jose informed this researcher that he had confidence in himself, and that he generally feels good about himself.

11. Attention from the opposite sex did not appear to be an extremely overwhelming need. In the one case with 18 year old Anna, she demonstrated that she did not need a lot of male attention from her peers, and eventually

did get engaged to a young man with whom she has had a long term, excellent relationship.

Maria stated that "I don't like people that swears or chase boys. Some of my friends do that, and I don't like it. I want them to act the way they should."

Anna's teacher stated, "She is very reserved with the boys. I remember a young man who wanted to date her, and she didn't want to date him. She told him off."

Jose, according to his teacher, seems to demonstrate a very healthy and appropriate interest in the girls. "The girls like him. Some of them want him as a big brother. He wants to socialize with American girls from what I observe in the corridors and from what he tells me."

12. All sources, as well as the students themselves, by significant responses suggest that emotional stability exists in each of them.

Maria's teacher stated that she appeared happy "99% of the time." Her guidance counselor stated that "she is very happy-go-lucky with what appears to be an "ideal" emotional tone. "She comes across as vibrant, well-adjusted and happy."

When asked when are you most happy, Anna replied, "all the time."

Her guidance counselor talked about how well Anna appeared to handle disappointments. "I had to tell her she wouldn't graduate this year, and she handled it well."

This researcher became aware of another situation that Anna handled extremely well, that typically causes considerable stress in other young ladies. She definitely believes and demonstrates that she can handle very difficult life situations.

Jose is a happy student, in the opinion of his teacher and guidance counselor. Jose describes himself: "I'm mostly happy."

13. School is a very positive, consistent experience for the comparison group students.

Maria's teacher had this to say about her:

> She is one of the most actively participating students in my class. She is well-motivated, and she is a very conscientious student. She is very concerned about how well she does in school. She was absent just once this year and was apologizing forever for it. She strives to do well in class and is not afraid to challenge teachers.

Anna's educational experience in Cape Verde did not provide a good foundation for her school experience in the US. Consequently, school has been a struggle for her. In spite of that fact she is a conscientious student. Her teacher had this to say, "She's very punctual; attendance is excellent. She was not absent one day this year. She will come after school if she doesn't understand something. She stays after school quite often looking for help."

Jose, who quite emphatically stated to this researcher, "I <u>love</u> school in America," is described by his teacher as a very conscientious student. "He is very seldom

absent. He seems to be very proud of this. He is one of those kids who came from one of the smaller islands, and the educational level, especially if they were from the interior, was very low. But I would say he is basically a motivated student."

14. The students in the comparison group did not view suicide as a method of dealing with problems.

"I think that people die when the day comes. They shouldn't try to kill themselves when something is wrong. They should think more about their future. Don't ever think the worst; think about the bright side. When they have a problem they should talk to someone."

Anna stated that she doesn't think about death, and that she has never ever been upset to the point that she contemplated suicide.

Jose expressed that he never thinks about death and has not ever contemplated suicide.

15. This researcher would like to conclude the analysis of the data in response to Question #4 with the following observation regarding the different views on the matter of racial/ethnic/linguistic differences, and how the impact differed for the two groups in the study population. There was not a clearly defined difference in this area between the two groups; however, this researcher perceived a difference in the degree to which racial/ethnic/linguistic differences mattered in

the lives of these students and would like to offer a possible hypothesis to explain this.

Although all six students made statements that highlighted the acquisition of English as extremely important in the acclimation process here in the United States, it was the group of suicidal students who seemed to be more aware of and affected by the prejudicial treatment of Cape Verdean immigrant students. Jose was the only one who did not feel that there was different treatment of their group by other students; however, according to their bilingual teacher, males generally move out into the larger community quicker by virtue of athletics, as Jose had done, and this researcher is confident that this plays a large part in his experiences and consequently his perception of the situation.

This researcher found that although Maria and Anna did note some differences in treatment, it seemed less significant in comparison to the emphasis on discrimination, and the pain caused by this isolation in the group of young women who had exhibited suicidal behavior. Perhaps this is due to the fact that the critical determinant is the already established level of self-esteem in the individual who experiences this isolation. All of the girls in the suicidal group had experienced isolation in their families and had low self-esteem. Perhaps the degree to which they felt saddened and further isolated by their

racial/ethnic/linguistic differences, may in part have been that this really was an exacerbation of pre-existing feelings of isolation and low self-esteem.

Conclusion

It is this researcher's opinion that to a large degree, the Cape Verdean immigrant adolescents in this study exhibited suicidal behavior for the very same reasons that other young people manifest these behaviors. Primarily serious family conflict, loss, feelings of isolation and rejection from family members and peers, and a lack of connectedness to a significant caretaker, which may have been the most overwhelming contributing factors. This researcher is convinced that the early experiences with loss were very critical elements in their 'suicidal path.' However, their experiences with emigration, culture shock, and racial/cultural/linguistic differences may have added just enough additional stressors to predispose them to a greater degree to suicidal behavior when the other more typical causal/contributing factors were present. They struggled to balance their membership in two worlds, often with conflicting values and traditions. The typical adolescent life in America, often unacceptable to Cape Verdean parents, combined with other life problems, frequently provide fertile ground for suicidal behavior.

Table 3 on the next two pages summarizes the results of the study. The causal/contributing factors that were highlighted by the theorists and other researches on the subject of **adolescent suicide** in the Literature Review were used to develop the table.

Table 3

Results of the Study

Factors Viewed as Underlying
Adolescent Suicidal Behavior

Contributing Factors	Number* Suicidal	Number* Non-Suicidal
Familial		
Parental Divorce, Separation, Death	3	3
Poor communication	3	0
Marital/Family Conflict	3	1
Child abuse	3	0
Parental unavailability	3	0
High parental expectations	0	0
Alcoholism/mental ilness	0	0
Job loss	0	0
Suicide in family	0	0
Adoption	0	0
Individual		
Low self-esteem	3	0
Peer pressure	1	0
Social isolation	3	0
Drugs/alcohol	1	0
Depression	3	0
Hopelessness/helplessness	3	0
Mood swings	3	0
High expectations	0	1
Loss of boy/girlfriend	2	0
Sexual adjustment	2	0
Physical illness	0	0
Mental disorder	0	0

Contributing Factors	Number* Suicidal	Number* Non-Suicidal
Sociocultural		
Low economic status	3	3
Ethnic differences	3	3
Linguistic differences	3	3
Racial differences	3	3
Family relocation	3	3
Impact of media	0	0
Legal problems	1	0
School Adjustment		
Attendance problems	2	0
Academic problems	1	0

*Number of students with contributing factors in their case histories.

There are 31 factors listed as underlying suicidal behavior in this table. The entire suicidal group (all three students) were positive for 15 indicators. On an additional 3 of these indicators 2 of the students in the suicidal group were positive. The entire group of 3 students in the non-suicidal group were positive for only 6 indicators.

The suicidal group had a total positive score of 55 on the indicators as compared to the non-suicidal group that had a total positive score of 20 on the indicators.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of the Study

This qualitative case study sought to identify possible causal/contributing factors of the suicidal behavior in several cases of Cape Verdean immigrant adolescents, and to determine if commonalities existed in this target group. Three Cape Verdean immigrant adolescent students who had manifested serious suicidal behavior, and three Cape Verdean immigrant adolescent students who had not exhibited such behavior participated in the study. A qualitative case study approach was utilized. The methodology of interviews and observations was employed. Students who had manifested serious suicidal behavior, were compared to each other and to students who had not exhibited suicidal behavior.

The following research questions guided this study:

1. What possible causal/contributing factors are present in the case studies?
2. What are the precipitating events in these cases of suicidal behavior?
3. Are there any commonalities in the causal/contributing factors in each of the cases studied?

4. What differences are noted when a comparison is made between the group of students that has exhibited suicidal behavior and the group that has not.

The study used the methodology of interviews and observations primarily; in addition, all cumulative records of students involved in the study were reviewed. Three Cape Verdean immigrant adolescents who had manifested suicidal behavior and who had been counseled by this researcher, and three Cape Verdean immigrant adolescents who had not ever presented as suicidal, and who appeared well-adjusted were interviewed. All of these students were in the Cape Verdean bilingual program at the high school. Interviews with significant professionals, one of each student's teachers and each student's guidance counselor were completed. Interview questions were designed to elicit responses to ultimately answer the research questions that guided the study. In summary, the questions sought to discover what theoretical paradigms and/or psychosocial contributing factors were evident or suggested by the individual cases.

The data revealed that the young women who exhibited suicidal behavior were troubled children who experienced parental loss through death, separation and emotional abandonment. They suffered physical and emotional abuse in their families, and two of the students had sexual abuse in

their histories. Their peer relations were problematic, and they experienced a great deal of stress related to their living in two worlds, one the traditional old world of Cape Verde and the other a much more liberal America.

Conclusions

Theoretical Implications

Theories of several experts in the field of suicidology are possibly reflected in the individual cases of suicidal behavior that make up this study. This researcher will summarize briefly those particular theories and offer a brief commentary.

Sociological Theory - Emile Durkheim

Durkheim's pioneering effort on the subject of suicide, Le Suicide (1897), asserted that suicide was an individual phenomenon and was man's reaction to the peculiarities of society. Durkheim saw suicide as a type of destructive behavior that can result from the type of control that society has over man.

Durkheim delineated four types of suicide (defined in the section containing definitions relating to suicide):
1)egoistic-man is alienated from community, family, friends.
2) anomic-failure of person to adjust to social change.

3) altruistic suicide-group authority over individual is so compelling individual loses identity and sacrifices the self.

4) fatalistic-rules and regulation of society allow for no personal freedom, no hope.

Durkheim's theory in part is suggestive of the lives of the young women of the study. It is conceivable to consider that the lives of each young lady in part reflect egoistic suicide in that there certainly appeared to be alienation from family. Fatalistic suicide might be the explanation in part for all three also, in that they were struggling for freedom from rigid traditions that at times for them seemed a hopeless struggle indeed.

Psychoanalytic Theory - Sigmund Freud

Sigmund Freud's contribution to the study of suicide was his psychoanalytic theory that would also serve to influence the future work of other theorists.

"According to Freud, suicide is a highly convoluted process related to depression and pathological mourning" (Orbach, 1988, p.14). This process stems from an ambivalent love-hate reaction toward a lost love object through rejection, death, or separation. Anger toward the lost love object becomes aggression turned inward.

"His essay 'Mourning and Melancholia' presents his theory of suicide. There are two kinds of drives: one is

the life instinct or Eros; the other is the drive toward death, destruction, and aggression, or Thanatos" (Grollman, 1988, p. 27). For Freud, death is more than a bodily event. Death is willed. There is a constant shifting of the balance of power of the two instincts. Suicide is aggression turned upon the self. Freud's theory is often summarized in the following statement: 'Suicide is murder in the 180th degree.' Freud's implicit value judgement is that murder is to be disapproved and prevented. Suicide, too, is murder turned about and must also be disapproved and prevented.

Each young lady suffered parental loss at an early age; Diana and Lidia, in this researcher's opinion appear to be greiving the loss of their father's still. Melinda believed that her mother had abandoned her, and later in life as a teenager in America, she characterized her father's rejection as "abandonment." These details in their lives might be part of a complex foundation for suicidal behavior, which in Freud's theoretical paradigm is related to depression and pathological mourning.

Alfred Adler

> To be a human being means to feel inferior. Suicide signifies a veiled attack upon others. Through an act of self-destruction, they hope to evoke sympathy for themselves and cast reproach upon those responsible for their lack of self-esteem. Adler described suicidal persons as inferiority ridden people who "hurt others by dreaming themselves into injuries or by

administering them to themselves" (Grollman, 1988, p.28).

All of the adolescents who exhibited suicidal behavior in the study appeared to have low self-esteem. In addition to the ultimate self-destructive act of each one of them, Diana made reference to other self-destructive behavior, "I used to always hurt myself." Melinda, too, made reference to turning anger on herself, "My grandparents used to hit me a lot; so when somebody hits me, and I can't hit you back, I'll do something to myself. I get so angry."

Theory of the Suicidal Career - Ronald Maris

Individuals exhibiting the suicidal career are persons who refuse to accept the conditions of their life. Generally they cannot find, or refuse to discover workable alternatives to suicide. They may employ non-suicidal coping methods such as alcoholism, isolation, violence, drugs, risk taking, which still border on suicide in that they lead toward self-destruction (Orbach, 1988).

Isolation to some degree became apparent in the lives of each young woman. Drugs and alcohol were also evident in Diana's life.

The Expendable Child - Joseph C. Sabbaath

The 'expendable child' theory states that conflictual families often produce children who are made to feel unwanted. Relations between parents are frequently very

unstable. This theory further posits that the child becomes a scapegoat for the parents' anger and weaknesses. Sabbath describes the suicidal child as extremely dependent on his parents and feels rejection, abandonment, and worthlessness as a result of the faulty family dynamics. When the situation becomes extreme the child does as he thinks his parents wish and eliminates himself. Life and family situations rather than personality dimensions are the prime motivator for suicide. (Orbach, 1988)

The conflictual family situations that characterized the homes of each of these adolescents, as well as the rejection they experienced, suggested to this researcher that they were in fact, "expendable children."

Accumulation of Problems and Ever-Growing Isolation

This model of adolescent suicide is characterized by a gradual decline into total social isolation which eventually leads to suicide. The youth sets out on the suicidal path when life problems are perceived as insoluble. He has no one to share his problems with and believes there is no solution. He sees himself as no longer a member of society and suicide as the only solution (Orbach, 1988).

Isolation was an increasing problem for these young women. Both Melinda and Lidia appeared to have no one in their families to turn to, and had no friends whom they trusted and felt close to. Diana experienced alienation

from family and eventually began to draw away from her friends, even though it appeared that she had better relationships with peers than the other young women earlier in the school year. Each of them expressed hopelessness about their life situations during counseling sessions with this researcher.

The Theory of the Unresolvable Problem

This theory embodies the "phenomenological state of mind that reflects the child's experience of being trapped and incapacitated" (Orbach, 1988, p.196). This model theorizes that young people viewing their set of circumstances as hopeless with no resolution frequently become depressed and eventually opt for suicide.

This aspect of the theory is essentially the same as the "Theory of Accumulation of Problems-Ever Growing Isolation."

Orbach speaks of the paradoxical facet of the unresolvable problem: "any attempt at resolution generates new problems in its wake. Sometimes, the very act of doing away with a problem becomes a source of difficulty in itself" (p. 202).

Diana's struggle with sexual abuse and attempted resolution appeared to be a classic example of the paradoxical facet of the unresolvable problem. It was when she went to the adults and professionals in her world to

address the assault (problem) that her home life worsened, she became revictimized by the system, she became hopeless, and ultimately attempted suicide.

Inheritance of a Pessimistic Attitude Toward Life

This theory holds that certain families suffer from various difficulties and pressures. Their pessimistic outlook on life, fatalistic style of speech, view of death, and submissive attitude are passed on to the children; either through identification or imitation or the formation of negative expectations of life. In most families of this genre children don't observe positive coping; they surrender and internalize anger. The message becomes life is hard and perhaps it would be preferable to die rather than suffer (Orbach, 1988).

On Nov 26, 1991 this researcher conversed with Marlene Lopes, Special Collections Librarian at Rhode Island College, a second generation Cape Verdean-American, who is an excellent resource person on the available texts on the Cape Verde Islands. The somewhat obvious pessimistic outlook that our forebearers seemed to exhibit was discussed. Their tone was often quite serious. The somberness at times seemed to forewarn children that they had to suppress their laughter and childlike ways in respect for life that required a persevering attitude and an expectation of impending disaster.

One of the students in the study who had exhibited suicidal behavior mentioned how her mother used to get angry when she laughed. In thinking about this, this researcher wondered how the history had fostered, or possibly caused this seriousness of purpose that went far beyond the norm of appropriate behavior for youngsters.

When one considers that the Cape Verdean history is replete with accounts of death to thousands as a result of the droughts and subsequent famines, it seems hardly likely that a lighthearted attitude could prevail in such austere times. There appeared to have been decades of extreme conditions for Cape Verdeans who not only had to endure the ravages of the droughts and hunger, but had to watch as sometimes 1/2 of the population succumbed to these desperate times.

If that depressing situation wasn't enough to cause a forlorn attitude, the response by Portugal, implored by Cape Verde to send help, certainly had to put the "remaining nails in the coffin."

According to Barrows (1991) when Cape Verde requested that President Salazar of Portugal send food to the famine stricken Cape Verde Islands, Salazar responded, "Go and open the cemeteries." (p. 119). Portugal refused to send any food or supplies to Cape Verde where people were dying everyday of hunger.

Although it is purely conjecture, this researcher questions whether there could be a predisposition to a very pessimistic attitude toward life for some immigrant adolescents coming from this third-world country, not too long removed from the desperation and degradation wrought by extreme poverty. This is certainly not meant to imply that all or most Cape Verdeans have a pessimistic outlook on life. This researcher's observations of her people clearly indicate an incredible capacity for many, if not most, to enjoy life life to the fullest, in spite of historical and contemporary suffering.

As the aforementioned theory suggests, some young people inherit a pessimistic outlook that could possibly provide fertile ground for depression and suicidal ideation when life "seems too much to bear."

This researcher maintains that this background or predisposition, at least for some, may make it easy to adopt a mental state of hopelessness and helplessness when problems arise in America, particularly when the disappointment sets in that even in the US, there is sadness and pain.

This researcher would like to discuss at this point a number of areas that were significant in the case studies that warrant additional attention.

Culture Clash Issues

We vs. I

A number of the Cape Verdean professionals commented on the major conflicts that develop in families as the socialization of young people begins. The Cape Verdean culture is a "we society" while the American culture is very much an "I" or "independent" society. Another way of expressing this difference is stated by Tony Gonsalves, "I think that what we are talking about is the difference between a cooperative society vs. a competetive society."

Alcides Pina discussed this as it relates to suicidal behavior, and his view is reflected in the dissertation case studies of the suicidal young women:

> ...another problem that I see happening in terms of suicidal behavior has a lot to do with the mixed messages that they get here in this country and this society. Back in Cape Verde students grow up to respect their teachers, their parents, and their elders, and they are very obedient. When they come here they are educated in school that they have their freedom, they have their own mind, and that they are their own person, and that somewhat conflicts with what they have been taught by their parents. What I have been able to observe in Boston is that there seems to be a lot of conflict between what the values that students obtain in the school system and the values that their parents instill, and it takes a tremendous amount of work to put everything into perspective. (Personal communication 12/11/91).

Padre Pio also felt that the individualism of this culture clashed with the Cape Verdean tradition of the family and community first:

> In America there is a great difference; the school doesn't always support the family. They speak too much about independence from the father and mother; this is very shocking to Cape Verdeans. Here it is very individual oriented; this is a very foreign concept to Cape Verdeans. Community and family is the most important part of the community; this is a big problem for the Cape Verdean family (Personal Communication, 12/29/91).

He knows a lot of families who have packed up and gone back. According to Padre Pio, they suffered too much. They said that while they were here in the US they lived a rich life; they had everything, but they didn't have that family structure like they did in Cape Verde. They wanted to go back where they would be poor, but at least they would be in peace.

The suicidal women in this researcher's study certainly upset their respective families when they began to expresss their individualism, primarily when they wanted to socialize individually and with peers, as opposed to socializing with family members at family or community functions exclusively, and they certainly did not want older brothers or relatives as chaperones. This was unacceptable behavior for the parents and older siblings and caused a great deal of the family strife in each of these cases, which contributed to their depression and suicidal behavior.

Maria Todisco and Paul R. Salomone (1991) discuss this contrast between Afrocentricity and Eurocentricity, which helps to explain a major area of culture clash in the experience of Cape Verdean immigrants in America.

> The African worldview (Afrocentricity) and the Western worldview (Eurocentricity) are in many ways opposite. Whereas concepts such as the value of the group over the individual, equality among all people, respect for all life, and cooperation are stressed in the Afrocentric worldview, the Eurocentric position 'values competition, individuation, and mastery over nature...' (Cheatham, 1990, p.5). In many Western societies the individual is seen as autonomous instead of interdependent; achievement and motivation are highly valued, anda strict time schedule is considered important. Another difference that is characteristic of the Eurocentric worldview is a certain ethnocentricy-a sense of superiority toward other orientations (p. 150).

Pregnancy/Sexuality

Culture clash in the area of sexuality is certainly an issue. Pregnancy in unmarried young women is virtually a taboo in Cape Verde, according to Joao Pereira (Personal Communication 1/8/92):

> In Cape Verde sometimes it happens that if a girl got pregnant and the boyfriend didn't marry her, and to save the honor of the family she might kill herself. This sometimes happens in Cape Verde. Sometimes the father would kill himself; it's a question of honor.

Alcides Pina cited a case of a suicidal pregnant young woman, (Personal Communication 12/11/91).

> Once I had a case, a young lady who was pregnant and in the process she was thrown out of the house by her parents, and also her boyfriend moved away, because he didn't want to accept the responsibility. Here was this 17 year old girl who was all alone and couldn't do anything; all of a sudden she became very depressed, didn't know how to cope with things; school performance dropped dramatically and this was a very tough situation to deal with. Parents have to be educated on these issues that they are really doing a big disservice whenever they behave in a way that some do. I want to emphasize that certainly not all Cape Verdean parents react this way, but some do. Her depression certainly did reach suicidal proportions. I referred

her to a crisis counselor and social worker, and we were able to work with her throughout the year, and I'm quite happy to say that she's doing quite well right now.

It is this researcher's contention that when these young ladies become victimized by the media blitz of sexual messages that bombard them constantly, this along with other issues, fosters problems. They often become pregnant, like other teens in the US. Unfortunately, the consequences for them as opposed to their American counterparts may be far more severe, given the cultural values pertaining to pregnancy in unmarried young women. Some are asked to leave the home that they have shamed, in the opinion of their parents, and they may have no where to turn. This frequently leads to depression and occasionally suicidal behavior. One young lady who was originally considered for the dissertation study was dropped just prior to beginning the student interviews, because this researcher deemed her to be too fragile. She had made an attempt with a prescriptive drug overdose when she learned that she had become pregnant. When she came to see this researcher seeking assistance, she was quite adamant in expressing that she did not want her family to know. In light of the cultural views on her situation, this attitude and fear were clearly understood.

One of the young ladies in the study who had made an attempt, and who was suicidal on more than one occasion, was

thought to be pregnant when she threatened suicide at one point. Although there were numerous problems, pregnancy would have only exacerbated her situation.

Male/Female Roles

Male/female role expectations are clearly a problem for immigrant females once they begin to acquire American values. They no longer want the subserviant treatment that is part of the cultural norms of their homeland. They are socialized from birth, it would seem, to accept their lot; and in Cape Verde this is not problematic. However, once in America, this is a serious culture clash issue.

This writer vividly recalls a group play session that became an interview session with a number of youngsters on San Pedro beach outside of Mindelo on August 14, 1989. Here is an excerpt from this researcher's journal entry of that day:

> We got to the beach and looked around at the small fishing village tucked away in the majestic mountains of Sao Vicente....Before long there were curious little boys coming near. I asked them many questions. I noticed that only little boys were out playing. When I asked about the little girls in the village, they told me that they were home working in the houses. Women's oppression starts right at the beginning, I thought. ....After a while some little girls came out to play. I talked to them, asking questions about school, etc. We asked them if we could take pictures, and they agreed. Even through the lens of my camera, the obvious difference between the boys and girls could be seen. The playfulness and wide smiles of those happy little boys were offset by the timid, serious, and more reserved young ladies, who smiled ever so meekly. They seem to be tired little women already.

This role difference certainly was an issue for the young women who were suicidal in the study as previously mentioned. They wanted to have the freedom, rights, and respect that they perceived all American women had as a birthright, but most important of all, they expressed a desire for equality of the sexes.

Discipline-Authorities

The Cape Verdean community is a very closed community, much like many other immigrant communities. They are used to handling their own problems and do not readily welcome the intervention of outsiders, even when the outsiders are authority figures, appropriately involving themselves in a particular matter. The outside involvement as a result of the sexual abuse of one of the suicidal young women in the study definitely contributed to her deteriorating family relations, and ultimately her suicidal behavior. The family angrily told her that she should not have told school staff members about the abuse; the mother wanted the older brother to take care of the matter, and not involve the law or anyone else outside of the family.

Significance of Death

Adolescent attitudes toward death figure significantly in the mental health problem of suicide and suicidal behavior. There is much evidence to strongly suggest that

teenagers often glorify death and that their views, much to the surprise of many, do not suggest a full and total comprehension of the finality of the objective state of death as is indicated by the following:

> Many teenagers and young adults-well into their twenties-have an unrealistic view of death. In their minds' eye they see themselves as wrapped in a cloak of immortality. Even those who attempt suicide usually lack a true concept of the finality of death (Klagsbrun, 1976, p. 47).

Cape Verdeans are a very community oriented people. They come together to support and comfort their own. This is very much the case when it comes to illness and death of a family member, friend, or aquaintance. Wake and funeral attendance is a serious commitment to a fellow Cape Verdean and takes priority over other items on one's calendar. Outsiders observing the size of funeral processions, or the frequent long lines outside of funeral parlors often conclude that someone of serious import must have passed on, when in reality, amongst Cape Verdeans, one appears to be elevated to the status of a well known individual merely by the occasion of one's death. At times it has been necessary to acquire a police escort to manage the automobile processions in Cape Verdean funerals in the city of New Bedford.

What does this kind of attention to the deceased communicate to a troubled young person, who might, like all others of his/her age group, glorify death anyway? Perhaps this appears to be a way of getting the sorely needed

attention, as well as a means to escape the pain. It would be difficult to discern the impact of this aspect of the culture, since behavior is not always at a conscious level. This researcher suggests that it is entirely possible that this cultural variable may play an unconscious role in the lives of some troubled and suicidal youth of the Cape Verdean immigrant community.

This writer would like to conclude the discussion section by highlighting some of the similarities noted amongst suicidal behavior in youth of color from different racial/cultural backgrounds. This attention is critical since understanding the similarities may provide an opportunity to better understand this mental health phenomenon in youth of color, and perhaps assist in the development of strategies to combat the problem of suicidal behavior in these special populations.

Calvin J. Frederick of the National Institute of Mental Health states that the following factors are significant influences on the issue of Native American suicide: alcoholism, drug abuse, self-destructive behaviors that result from dissolution of traditional Indian lifestyles, menial jobs and low job skills; and the migration toward large cities and stress (Hafen, 1986). Parental losses through divorce or desertion were much higher in incidence

among suicidal Native American adolescents compared to non-suicidal Native American youth.

Jack C. Smith et. al. (1985) attempted to investigate self-inflicted violent behavior in Hispanic Americans: "differences in the patterns of Anglo and Hispanic suicide probably reflect an interplay between the effects of the diminishing influence of Mexican cultural traditions, the increasing influence of American culture, and the marginal socioeconomic status of Mexican Americans."

Arthur R. Copeland (1989) studied studied suicide in Blacks and other nonwhites in the bilingual, multi-ethnic community of Miami, Florida.

> Suicide among Black-Hispanics and Haitians has not been discussed elsewhere. ...One must realize that these high-risk groups have faced 'culture shock' in emigrating to Miami. Black-Hispanics have been removed from a more thoroughly integrated society in Cuba or South America. Haitian alienation from the American Blacks (e.g. language difference) ... may lead to depression (p. 13).

Cape Verdean immigrants, to some degree, are experiencing these very same problems, which may contribute to their depression and suicidal behavior.

Recommendations to Address the Problem

It should be stated at the outset that 'adolescent suicidal behavior' is a community problem rather than a school issue exclusively; however, as Vidal (1989, p.12) says, "The real challenge for educators will be in the

involvement of communities in the resolution of the teen suicide epidemic." He further states that the school environment "provides a very logical setting to be in the vanguard of the resolution of this problem. The school lends itself to intervention that may be difficult elsewhere. The interaction between young people and adults present opportunities for responding to the youth in crisis."

Schools have long been a symbol of educational leadership in any given community. This is where learning takes place, learning in a variety of ways and learning in a variety of areas. Therefore, this researcher believes that schools should quite naturally be in the vanguard of the resolution to this distressing mental health crisis of adolescent suicidal behavior.

The role of the school is pivotal in the adolescent suicide prevention issue. Efforts toward prevention should start here since schools have ready access to adolescents. They also have access to the adults who are closest to them, their parents and teachers. It must also be remembered that teens spend more time in school than in any other structured environment outside of their homes. Teachers and others in the school environment are on the front lines and in an excellent position to know early on when a teen is in trouble.

A number of the recommendations are important considerations for suicide prevention programs for adolescents in general; however, they are equally as important and included with the recommendations that are specifically advised for this special population.

Schools and parents must form a partnership committed to working toward the goal of educating immigrant adolescents as well as assisting them in their process of becoming happy, well-adjusted, productive young adults in a new world environment.

Professionals familiar with the three major Cape Verdean communities discussed in this dissertation (New Bedford, Boston, and Brockton) and their school systems expressed concerns about the difficulties immigrant parents have in becoming involved in the educational process of their children. The language barrier does present some problems, however, it is suggested that schools try to do more to make parents feel welcome. Quite frequently they feel intimidated by the professionals responsible for the education of their children. One educator expressed it this way:

> Our parents have to be involved, and I think that they don't always feel welcome to come in and be involved. We cannot do it by ourselves; the administrators have to be accountable in this process, too. They have to be involved in bringing our parents forward to participate in the educational process of their children.

A number of programs and services are appropriate for immigrant students, depending on their individual needs. The following might be considered:

Special Orientation Program for New Students

A special orientation program to help acclimate immigrant students to their new country, city, community, and school is defintely a worthwile undertaking. The kinds of major changes and adjustments inherent in leaving one's homeland, settling in a new country with different values and traditions are extremely difficult. The language barrier is an additional hurdle for these young people. If they were made to feel especially welcome by a carefully tailored orientation program, some problems of adjustment might be eliminated before they surface.

Counseling/Support Groups for Immigrant Adolescents

A great deal of stress is experienced around racial/cultural issues inherent in coming to America and adjusting to a very different culture and a very diverse population. Cape Verdean immigrant students also have the language barrier to contend with. Not all students experience difficulty adapting; however, a support group to

address the issue of living in two worlds should be considered for the students who do have adjustment problems.

Big Brother Big Sister Program

Linking the Cape Verdean immigrant student population to the Cape Verdean/American population to minimize the isolation and estrangement from the American born students who share the same heritage would be a plus for both groups of students. All of the students in the study felt it was sad that there wasn't a closer relationship between these two groups. The immigrant group possibly would feel a greater belonging to the school if this link were available, and the American born Cape Verdean students would perhaps improve their self-esteem through this helping process and as a result of coming to a greater awareness of their cultural heritage, and perhaps would even learn the language of their forebearers.

Peer Leadership Program

This researcher is recommending a Peer Leadership for the entire school population, but one that would encourage Cape Verdean immigrant students to participate. "Peer counselors are a resource often overlooked by the school" (Patios and Shamoo, 1989, p.198). This researcher is in

favor of establishing Peer Leadership programs for all secondary schools. Many of this counselor's referrals of suicidal adolescents from all ethnic groups came from friends of the troubled students. This was also true of the Cape Verdean students. Frymier, (1988) cites the fact that 75% of teenagers who are severely depressed or suicidal turn to their peers. So whether we like it or not, peer counseling is going on and will continue to go on. It makes good sense, therefore, to develop this resource.

This is probably even more critical with Cape Verdean immigrant students because they are still emersed in a culture that is not accustomed to turning to professional counselors or therapists. This segment of the professional community is virtually non-existant in Cape Verde, and not readily used by Cape Verdeans in the immigrant community in the U.S.

A major component in establishing a peer leadership program would be a **"Suicide Awareness Program"** so that young people would recognize the cry for help from their friends and to be prepared to direct them to the appropriate adults. It should not be the intent of the Peer Leadership Program to encourage students to "counsel" other students. Their role should be limited to recognition of warning signs, referral, and support, according to Thomas Barrett (1985).

Educational Workshops

Understanding Adolescence

Adolescence is a developmental stage of life that confuses and frustrates even adolescents. A seminar to help them better understand the characteristics of this period in their lives would take away from the 'I'm different, I'm strange, I'm crazy,' feeling that often pervades this group. Understanding that certain characteristic behavior is normal would undoubtedly reduce stress. Parents also need an Adolescent Awareness workshop so that they might better understand that some of the upsetting behaviors in their offspring are merely developmental milestones.

Stress Management Techniques

Adolescence is a very stressful period. In their struggle for independence and intimacy we ask them who they are, what they want to do, how and with whom they want to spend the rest of their lives-we ask them to make extremely important decisions. Yet, at the same time we ask them to defer gratification, stick to a course of study, curb their desire for independence, submit to the authority of educators, parents, etc.

This dilemma is extremely stressful and often results in illness, disciplinary problems, chronic absenteeism, psychosomatic behavior, vandalism, delinquency, feelings of

worthlessness, episodic moodiness that can turn into severe depression; if persistent and prolonged, suicide can result (Youngs, 1981).

Students would benefit a lifetime by learning stress management techniques such as relaxation, imagery, meditation, and other coping mechanisms (Patros & Shampoo, 1989).

Social Skills Training

Many suicidal students are loners, or youth who just never learned how to interact with peers and adults. Specific skills such as making friends, relating to and helping others, controlling anger, being assertive, etc. would probably improve the lives of many (Patros & Shampoo, 1989). The isolation of the immigrant student is a real concern for professionals, since this is often a contributing factor to suicidal behavior. Social skills development would contribute in a positive way to this problem.

Relationships

In light of the fact that the end of a relationship frequently precipitates a suicidal attempt and/or suicidal ideation, this researcher would like to see workshops/groups for teens that address relationships. Objectives might include such areas as communication in relationships,

sexuality, respecting one's partner, breaking up responsibly and sensitively, as well as other concerns that surface in teen relationships.

Communication

Suicidal adolescents tend to have serious difficulty in communicating with their parents and in feeling accepted by them (Peck, 1984). Learning effective communication skills would be extremely therapeutic and helpful. Parents need to participate in such workshops also. This researcher constantly hears from parents and students alike that 'no one is listening' or that the level of communication is a 'talking/screaming' at each other affair. Cultural factors would need to be taken into consideration, however, since there are very strong beliefs in old world families regarding appropriate adult/parent/child communication.

Self-Esteem

Self-esteem influences behavior in all persons, but it is especially problematic for troubled youth. Workshops and groups that focus on self-esteem building should be considered for preventative programs. Underlying many serious problems with young people is poor self-esteem, as this dissertation study indicated.

Creative educators can adapt to their particular schools and students many types of workshops and class

experiences to enhance the lives of students in general, and they certainly would benefit immigrant adolescents who feel frequently insecure in a new world.

Decision-Making and Problem Solving Skills

Stupple (1987) advocates providing students with training in making their own decisions. Adolescents often view their actions in isolation and do not see how their decisions/actions affect others; this is essential training. Developing problem-solving strategies is additional life skills building that helps to reduce the stress in everyday living.

This recommendation is appropriate for all students, but must be carefully handled with Cape Verdean immigrant students, so that values of the culture are not trampled upon. In many households, for example, parents do make the decisions for the children; decision-making skills should not be presented in such a way that students adopt a policy of outright challenge to cultural norms.

Alcohol and Drug Awareness Education

Suicide Prevention programs for all students cannot avoid the alcohol/drug abuse issue if they truly want to address the major adolescent problems contributing to this mental health issue. However, substance abuse is becoming a

serious problem in some Cape Verdean communities. The problem of alcoholism is one that concerns the Cape Verdean community in general, and therefore warrants attention, given the high correlation between substance abuse and suicidal behavior.

Sex Education

The issue of teenage pregnancy is one that concerns this nation as a whole, and educators and parents of all young people in particular. However, the cultural issues that surround the pregnancy of a young, single Cape Verdean immigrant female, makes it imperative that this group receive information that may in fact prevent the sometimes difficult emotional situation they experience with an unplanned pregnancy. They come to this country with their values tucked inside, but then are bombarded, like all other youth, with the sexual messages that certainly contribute to the relatively more relaxed values and beliefs about pre-marital sex and pregnancy of young, unmarried women.

This researcher to date has had to deal with the issue of pregnancy, depression, and suicidal behavior in this population several times. Beyond the obvious emotional issues previously discussed is yet another concern. In two cases, the suicidal young women ingested pills in the attempt to "end it all." This cry for help was responded

to and help was provided to deal with the psychic pain. Potential for future problems existed, however, if the ingested medication had harmed the fetus; they were all in the first trimester of pregnancy when the attempt occurred. Is it possible that a lifetime of guilt, if not depression, could have resulted if the child were impaired? It is this researcher's opinion, therefore, that sex education for this group is of paramount importance. This issue of pregnancy points out the the differences between various groups, since all minority group females do not share the same views, values and overwhelming shame when young, single, and pregnant, that appear to be part of the pregnancy experience for the immigrant Cape Verdean adolescent female. Certainly this does not apply to all female members of the group. The younger the time of arrival to this country, the easier it appears to be to accept this situation, since the young person may have a more liberal, Americanized view of single motherhood and/or pre-marital sex.

Sex education also has to take into consideration religious views.

Culturally Sensitive Professionals

Cape Verdean teachers and school counselors, and mental health workers familiar with ethnic minorities are critically important. The value of positive role models for

all young people cannot be overestimated. Minority youth, in particular, have too few role models from their ethnic groups. Appropriate role models contribute to a positive self-image. Teachers who share the same cultural background may also be able to recognize personal problems early on, which might prevent more serious difficulties in the future.

McRae and Johnson (1991) very succinctly state the significance of proper training of mental health workers dealing with diverse populations:

> If we are to prepare counselors to work effectively in a pluralistic society, it is clear that counselors must not only be aware and knowledgeable about cultural variables but also be aware of themselves as cultural beings and able to read and create relational contexts that are therapeutically appropriate and culturally relevant. Applying cultural knowledge effectively in a context of a cross-cultural relationship must form the skill base for clinical competence in cross-cultural counseling (p. 135).

The schools should consider staff needs to address problems of special populations such as this ethnic group.

This researcher is confident that without a doubt, membership in the Cape Verdean ethnic group has helped Cape Verdean adolescents respond to her more comfortably, because they sense in this counselor an understanding from the heart which transcends the professionalism acquired through the academic. In some of these cases, this group membership may have made the necessary difference. This is not meant to imply that one cannot work successfully with immigrant

adolescents or adolescents from old world households unless one has membership in the cultural group in question. This researcher has observed fine work done with ethnic minority students by non-minority colleagues, and this researcher, too, has made a significant difference in the lives of students from ethnic groups other than her own. However, in some critical cases, particularly if the adolescent is from a very old world Cape Verdean home in this closed society, one's interpretation of the situation, or one's ability to offer appropriate recommendations to alleviate the crisis, may be dependent upon information that is difficult to know and intuitively fathom without group membership. Also, the adults in the family may not readily receive the well-intentioned assistance from an outsider. Sometimes even group membership does not guarantee that intervention of any kind will be welcomed.

Cultural Awareness Programs in Schools

Special programs such as multi-cultural awareness events that involve the entire school highlighting and celebrating many cultures would be a wonderful opportunity to promote brotherhood and sensitivity to persons of different ethnic backgrounds. Introducing the Cape Verdean culture to the general school population would perhaps enhance the self-esteem of immigrant students and lessen

feelings of isolation that some students may feel. Many schools serving multi-cultural populations successfully implement such programs. Cultural sensitivity and awareness has long been a major goal of the New Bedford Public Schools and certainly contributes to positive self-esteem in all youth. However, it is especially important to immigrant youth seeking to feel a sense of belonging in their new communities.

Community Awareness Service

Establishing a network of communication and assistance for Cape Verdean families would be extremely beneficial. Cape Verdean families would benefit in becoming aware of just what community services and programs are available. The Churches in the community could be utilized to assist the schools and other agencies when families have special needs.

Alcides Pina (Personal Communication 12/11/92) spoke to this need, which reflects this researcher's recommendation.

> A lot of issues are tied to the Cape Verdean community; I think that the Cape Verdean people in general are very conservative. For a long time we have been accustomed to not going outside our own group with whatever problems we have, but to keep the problems within our community and help each other out. But times have changed; there are so many problems in our society right now that it is virtually impossible for us to help ourselves exclusively, and I also think that what we need is funds to establish programs in our community to help our teenagers, to help our young

people, because I feel that it is here that we have the most severe problems.

Parent Groups

Parents need special groups or seminars in their native language to assist them in their difficult adjustment to a new country and to assist them with their children. The following are possible considerations for Parent Groups:

Nature of Adolescence

Adolescence is a developmental stage that confuses and frustrates all parents, but Cape Verdean parents, given the cultural differences, have difficulty understanding the drive toward independence and separation from the family. Some behaviors that are very normal and more acceptable in this country are foreign to them. Awareness groups might eliminate a great deal of family stress.

Appropriate Discipline

There have been many misunderstandings and serious problems resulting from a different form of parenting and disciplining in the United States; particularly when one considers the recent social awareness of **child abuse** and the legislation that has been enacted in recent years to combat this problem. It is common practice in Cape Verdean households to discpline children physically. Well-intentioned professionals, not wanting to neglect their

charges, have on occasion reported instances of physical punishment that did not constitute child abuse, while some of their professional peers have overlooked cases of outright abuse, ignorantly writing it off to "that's their way of parenting, and it's not our right to get involved." This is in clear violation of the statutes in Massachusetts; however, this dilemma of determining the fine line between legally acceptable physical discipline and abuse has on occasion erected barriers between the professional community (the schools and/or the Department of Social Services), and the Cape Verdean family.

There is a need in this area to establish a dialogue and offer services if indicated to assist families with severe discipline problems, particularly with adolescents, who by nature are about the task of separating from the nuclear family. This is a difficult problem for the Cape Verdean family.

Padre Pio expressed that there have been "a lot of false accusations of child abuse." He spoke of a number of cases where he had to intervene on behalf of parents who had not crossed the line between physical discipline and abuse, and in one such situation, he went to court with the family and was very instrumental in preventing a tragedy for a family destinied to be split up by the court, when clearly cultural differences caused communication problems.

Joe Evora explained beautifully it well during our interview:

> In cultural terms, I'd like to add this, new families, new immigrants aren't going to change their values in one, perhaps not even two generations. It takes a long time to forget, to put aside your values and embrace fully and understand a new system of cultural values. I saw an article a few months ago about discipline in the US 30 years ago and beyond; corporal punishment was common. Now they look at people who use corporal punishment as being barbaric, as being bad. I can't agree with that, and then again I cannot condone spanking the kids and leaving marks.

This need might be better handled by a community group such as the church that has a greater connectedness with the family, working in concert with the appropriate professionals (ideally of the same cultural background) and the families.

The churches in the Cape Verdean communities usually serve a far greater role than providing places of worship only. Quite often they function as community centers, and given this reality, the churches can serve a very useful function as a liaison between the families, schools, and other community agencies.

Understanding Your Child's School and Student Responsibilities

Many students have a tremendous amount of responsibility at home, and their school work sometimes suffers because parents are unaware of the demands of a typical secondary school program. This conflict increases

tension and stress for the family and student if the youth appears to be neglecting the home responsibilities to do school work. It is also a source of depression for some immigrant students. Many Cape Verdeans did not have the opportunity to complete the first cycle of Education in Cape Verde, and the majority have not had an opportunity to undertake secondary education. Therefore, this whole notion of homework and projects might be totally foreign to them. This researcher has experienced this problem with several immigrant students.

Community Effort to Address Social Problems

A community effort to address the violence, drugs and societal ills that contribute to the self-destructive behavior in our youth is desperately needed. Suicidal behavior in our youth takes many forms. Sometimes the most overlooked suicidal behavior is the sub-intentional suicide that takes the form of aberrant social behavior, particularly the violence and victim precipitated homicide that often overwhelms communities in the guise of gang activities, etc. Tony Gonsalves discussed this as a better indicator of the real picture of suicidal behavior in the Cape Verdean immigrant community. His suggestion is that we address this problem which will certainly decrease the senseless deaths of many of our youth.

"if we could focus on the social suicide of the adolescent Cape Verdean immigrant, then you are in a sense insuring that they don't die."

Summary of Recommendations to Address Problem

Recommendations to address this serious mental health problem include school programs for students to address their needs, which include groups to offer support and classes or groups to improve self-esteem, communication, stress management, social skills, understanding adolescence. Drug and alcohol awareness programs, as well as sex education programs for all students would improve the general adolescent suicidal problem and cannot be overemphasized for this ethnic group given its problems in the area of alcoholism and teen pregnancy. Parent groups are also recommended to help families deal with conflict, discipline, adolescent issues and the acclimation process. School staff and mental health professionals need to be equipped to address the needs of a multi-cultural society, and they should be provided the necessary training to accomplish this objective.

Recommendations for Further Research

This dissertation should be viewed as an initial effort in examining a serious adolescent mental health issue in a

unique population heretofore unstudied formally. Why should this group be isolated and addressed individually, rather than keep it under the umbrella of a racial minority group and address the problem (as has been tacitly suggested by the lack of individual statistics on this group)? The Cape Verdean immigrant family and the Cape Verdean immigrant adolescent bring to mental health professionals a background and experience that are unlike the profile of Black American individuals, with the exception of the obvious racial commonality. Therefore, they must be addressed differently in some matters to insure programs and procedures that will in fact address their unique needs, as well as their common problems germaine to all minority and immigrant groups.

Dr. Chukwudi Onwuachi-Saunders addressed the issue of race and ethnicity during the proceedings of a workshop entitled "Research Perspectives on Depression and Suicide in Minorities" sponsored by the National Institute of Mental Health (7/8/87, p.28).

> Race and ethnicity are different dimensions: race is a biological dimension and ethnicity a cultural distinction, although obviously there is some overlap. ...These differences between race and ethnic groups, and within these groups over time, should be explored more fully, as they may suggest specific hypotheses about the causes and prevention of suicide.

Research of suicidal behavior in this particular group of adolescents in cities and towns where they reside in significant numbers, and particularly where immigrant adolescents are enrolled in school systems in great numbers

is essential. It is suggested that Boston and Brockton, Massachusetts, as well as Providence and Pawtucket, Rhode Island are definitely municipalities where further study of the problem would be extremely beneficial to the recipients of services and the community at large. The magnitude of this mental health issue in this immigrant population is not clear at this time, but it certainly is an issue. Before appropriate address of the problem can take place, statistical data is needed to clarify the severity of the adolescent suicidal behavior in the Cape Verdean immigrant population.

This researcher was extremely frustrated in attempts to obtain statistical data from various state departments, hospitals, etc. on the incidence of suicidal behavior amongst Cape Verdeans in general and adolescents specifically. The state does not keep statistical data on the incidence of completed suicides or self-inflicted injury in this population saparately. In 1989 the Massachusetts Department of Public Health did begin to keep statistics on Cape Verdeans and had recorded no incidences of adolescent suicide in this population, and only one completed suicide of a young adult. However, completed and obvious acts of suicide do not tell the whole story of this mental health phenomenon. For the most part Cape Verdeans are classified according to the perceived racial category. This means that the statistics for this group would be impossible to gather

in looking at the statistics for racial populations, since some Cape Verdeans would be considered Black while others would be considered White.

The same problem existed in trying to obtain statistical data for background information on Cape Verdeans in the city of New Bedford, since they are not counted separately. There are population estimates, but it is difficult to determine exact numbers of this ethnic group, due to the often politically entangled issue of race and ethnicity that surrounds this group. The Cape Verdean Recognition Committee has been struggling unsuccessfully to have Cape Verdeans counted as a separate group, since there are many situations, such as in determing needs and numbers of this population, when this information would be crucial. The professionals this researcher interviewed in Brockton reiterated this same problem of trying to statistically determine the population of Cape Verdeans in their city.

Beyond researching suicidal behavior that manifests itself in a straightforward manner, Tony Gonsalves suggestion that we research the incidence of violent deaths amongst Cape Verdean immigrant adolescents is critical.

Dr. McNamara of Brockton Hospital, although he did not feel that suicide was a major problem in this population, did comment on the violent deaths of young people in this ethnic group in Brockton. "We have certainly had a lot of

murders of young people here..." (personal communication, 12/11/91).

Perhaps psychological autopsies on these youths would reveal just what percentage of these deaths were, in all probability, acts of suicide.

This researcher would like to suggest further investigation into the suggestion that there may in fact be a greater incidence of suicidal behavior manifested by students coming from the island of Fogo. It is not surprising that this group of young people would exhibit this behavior more frequently, if we consider the impact of family history and modeling, which the experts state are factors in suicidal behavior. Having a history of suicidal behavior in one's family is considered to be a risk factor by most practitioners, as well as theorists.

This researcher concludes that Cape Verdean adolescents are opting to cut short their lives, or at least to seriously consider ending it for the very same reasons that other adolescents do. However, their unique history and culture makes some of these very same issues more intense, and perhaps make them more predisposed to suicidal behavior than their non-Cape Verdean contemporaries, since they have to deal with the issues of immigration and culture shock that add to the burden of contemporary life faced by all adolescents. Additionally, some Cape Verdean youth, for the first time in their lives, are forced to deal with

discrimination based on language, ethnicity, and race which are often overtly expressed in this nation. If they are made to feel "less than" their American-born counterparts for these reasons, it may lower self-esteem that may be poor already due to other causes.

Summary of Recommendations for Future Research

Recommendations for future research include formal studies of adolescent suicidal behavior in towns and cities with large Cape Verdean immigrant populations such as Boston, and Brockton, Massachusetts and Providence and Pawtucket, Rhode Island. Included in these studies would be research on victim precipitated homicide, and other forms of sub-intentioned death.

******

How ironic that the persuit of the American dream of freedom and prosperity for these impoverished families quite often results in a veritable nightmare for a few lost souls struggling to balance their membership in two worlds; one that they have left behind, only to have her traditions and customs revisited upon them in insidious ways; and the other luring them to the temptations of adolescent life in America and different traditions that are often unacceptable to their families. The complexities of these young lives and this constant dilemma frequently erupt into the nightmare of suicidal behavior.

APPENDICES

APPENDIX A

LETTER OF REQUEST TO DO STUDY

(This letter was a follow-up to a lengthy telephone discussion about the dissertation and the study proposed.)

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SUPT'S OFFICE

April 12, 1991

Mr. Constantine Nanopoulos
Superintendent of Schools
New Bedford Public Schools
New Bedford, Mass.

Re: Request to do Dissertation Study

Dear Mr. Nanopoulos,

I am forwarding to you excerpts from my dissertation proposal for your perusal. I would like to request permission to do the study as described herein.

I hope that you will recommend approval to the School Committee of New Bedford.

Thank you for your consideration.

Sincerely,

Marlene Rodrigues-Andrade

APPENDIX B

LETTER OF APPROVAL TO DO DISSERTATION STUDY

NEW BEDFORD PUBLIC SCHOOLS
PAUL RODRIGUES ADMINISTRATION BUILDING
455 COUNTY STREET
NEW BEDFORD, MASSACHUSETTS 02740
(508)997-4511

CONSTANTINE T. NANOPOULOS
Superintendent of Schools

Assistant Superintendents
JOSEPH S. SILVA, JR., Ed.D.
Elementary Education

WILLIAM H. MARGINSON
Special Services

WILLIAM F. CHAPMAN
Personnel Services

Administrative Assistant
STEVEN B. LAMARCHE
Business Services

May 1, 1991

Ms. Marlene Andrade
Crisis Counselor
New Bedford High School

Dear Ms. Andrade:

At the regular meeting of the New Bedford School Committee held on Monday evening, April 29, 1991, it was voted unanimously to grant your request for permission to do your dissertation study as described in your proposal.

Yours truly,

Constantine T. Nanopoulos

CONSTANTINE T. NANOPOULOS
Superintendent of Schools
Secretary, School Committee

CTN:gm

cc: Wm. Marginson
N. Palmer
T. Calnan

APPENDIX C

ORAL EXPLANATION OF DISSERTATION STUDY

I have been concerned about the increase in adolescent suicidal behavior for a number of years. In particular, I am concerned about the increase in suicidal behavior amongst Cape Verdean immigrant adolescents. For this reason, I decided to focus my dissertation study on this particular group and problem.

I will be interviewing several Cape Verdean immigrant students who have exhibited suicidal behavior and several students who have not. In addition, I will be interviewing one of each student's teachers and each student's guidance counselor. All information will be kept confidential, and students or parents may withdraw student participation at any time.

I am hopeful that my research ultimately proves beneficial to students, families, and professionals who work with Cape Verdean immigrant adolescents.

If you have any questions now or at any future time about my work, please don't hesitate to ask them.

Thank you for agreeing to participate in this research study.

APPENDIX D

PARTICIPANT CONSENT FORM - PARENT VERSION

Marlene Roderiques-Andrade, M.Ed., CAGS

University of Massachusetts

School of Education

Amherst, MA. 01003

My signature below indicates that I am granting permission for my child to participate in a dissertation research project conducted by Marlene Roderiques-Andrade. An oral explanation of the project on Adolescent Suicidal Behavior has been presented to me.

I understand that my name and my child's name will not appear on any written documentation.

_____

date

_____

signature

_____

child's name

APPENDIX E

PARTICIPANT CONSENT FORM - STUDENT VERSION

Marlene Roderiques-Andrade
University of Massachusetts
School of Education
Amherst, MA. 01003

I agree to be interviewed by Marlene Roderiques-Andrade for the purpose of dissertation research. I understand that with my consent that one of my teachers and my guidance counselor will also be interviewed about me.
an oral explanation of this project has been presented to me.

I understand that my name will not appear on any written documentation or audio recordings.

I understand that I may withdraw from participation in this study at any time.

_____

date

_____

signature

APPENDIX F

INTERVIEW GUIDE - STUDENT

Name:

Age:

Year in school:

How long at New Bedford High School:

1. Where were you born in Cape Verde?
2. Who did you live with in Cape Verde?

   What did your parents do for a living in Cape Verde?

   What do they do for a living in America?

   How many sisters and brother do you have?
3. Were you ever separated from your parents?
4. What kind of childhood did you have in Cape Verde?
5. What does it mean to you to be Cape Verdean?
6. If you were asked what is your race, what would you say?
7. When did you come to America? How old were You?

   What do you like most about America?
8. What do you dislike most about America?
9. Would you want to return to live in Cape Verde?

10. Tell me about your relationship with your mother and father. What is the most important thing that you learned from your parents?
11. Compared to American or Americanized parents, are your parents more strict or less strict about letting you do things that teenagers do, e.g. going out with friends, dating, curfew?
12. Do you have chores at home? privacy?
13. How do you get along with adult relatives other than your parents?
14. How do you get along with your sisters and brothers?
15. What one thing would you change in your family?
16. Is there a difference in the way that boys and girls are treated, raised in Cape Verdean families?

17a. What religion are you?

b. While in Cape Verde did you go to church? regularly?

c. Do you have a fear of God?

d. What does your religion teach about suicide?

e. How do you feel about that?

f. Did you ever hear discussions about suicide in church or at home?

18. Did you go to school in CV? Tell me about your school experience in CV?
19. What special problems do Cape Verdean young people face when they come to America?
20. How do you feel about school in America?
21. Do you get along with your teachers?
22. What do you like most about school?
23. What do you dislike most about school? Have you ever had any problems at school? What happened? Do you have difficulty learning?
24. How do Cape Verde students who were born in Cape Verde get along with in America for a very long time?
25. How do Cape Verdean students who have not been in America for a very long time get along with other American students? Hispanic students? Portuguese immigrant students? Black American students, etc.?
26. When are you most happy?
27. What makes you happy?
28. How do you feel most of the time? How do you feel about yourself?
29. What makes you sad?
30. Tell me about the best day in your life? worst day?

31. Do you think about death? (If yes) tell me about the last time that you did? Have you ever felt so bad that you have thought of hurting yourself or suicide? Have you ever known anyone who attempted or committed suicide?
32. Do you have a lot of confidence in yourself?
33. Are you successful in doing most things that you try to do? Do you usually finish projects that you start? Are you usually satisfied/dissatisfied with the way they turn out?
34. What do you like to do best? What kind of activities? hobbies? interests?
35. If you could get up one day and do whatever you wanted, what would you do?
36. Are your interests similar to or different from other young people your age?
37. Do you feel satisfied with your group of friends? Tell me about them.
38. Do you use drugs or alcohol? If not, why not? If yes, why?
39. Do other young people usually like you? boys? girls? What do they like? dislike?
40. Do you like to spend time alone? How much? What do you do?

41. Would you rather spend your time alone or with people your age? younger? older or adults?

42. Have you had any problems in the last couple of years? What were they, and what has happened? (If students who were referred for suicidal behavior do not discuss that experience in question #31, and do not refer to the experience at this time, I will ask them the following question: Would it be to painful for you to discuss...[I will briefly refer to the incident])?

43. What do you do when you have a problem? Does it help?
    Have you ever seen a therapist outside of school? What were the circumstances? Was it helpful, why or why not?

44. Tell me what you think your life will be like in ten years? Where will you live? How will you feel? Will you marry or have children? What will you be doing?

45. If you had three wishes, what would they be?

Thank you for doing this interview with me. Would you like to tell me how it felt doing it?

APPENDIX G

INTERVIEW GUIDE - GUIDANCE COUNSELOR

1. How long have you been _____'s guidance counselor?
2. How would you describe _____'s adjustment to New Bedford High School?
3. How would you describe _____ as a student? (attendance, responsibility, motivation, enthusiasm)
4. Generally speaking, how would you describe _____'s emotional tone?
5. How does _____ handle disappointments?
6. Does _____ appear to have close friends? What suggests this?
7. What is _____'s intellectual level? On what do you base this determination (standardized tests, etc.)?
8. What is you observation of _____'s social skills?
9. How does _____ interact with adults, peers, family?
10. What is your knowledge of _____'s family background?

11. Is there a history of suicidal behavior/completed suicide in this family?
12. What is your knowledge of his/her personal problems?
13. Does _____ confide in you about personal problems? Is it easy for him/her to discuss personal problems? Does _____ express feelings easily?
14. Do you have any additional comments about this student that you would like to offer?
15. Do you have any comments or suggestions about the this interview that you would like to offer at this time? If you would like to think about the process you just engaged in with me, and would like to offer comments, etc. at a later time, that would be appreciated.

APPENDIX H

INTERVIEW GUIDE - TEACHER

Prior to beginning the interview, the teacher would be shown the consent forms signed by the student and parent. I would ask if they have a clear understanding of my research study before beginning.

1. What is your teaching assignment?
2. How long has _____ been a student in your class?
3. Does _____ actively participate in your class? Is he/she motivated? conscientious? industrious? punctual? frequently absent? Please offer any other remarks that come to mind regarding your observations of this student in your class.
4. Does he/she appear to have friends in the class, school community? On what do you base your conclusion regarding peer relationships?
5. Would you describe _____'s social skills?
6. How would you characterize _____'s emotional tone in general? Are there mood swings or does he/she present fairly consistently?

7. Does _____ ever discuss personal problems with you? Would you be specific.

7. Do you have knowledge of his/her personal background?

8. Do you have any additional observations, comments, or information on this student that you might offer?

APPENDIX I

OBSERVATION GUIDE

Name and position of person observing:

Name of student being observed:

Date:

Time:

Place:

Comment on the following:

Physical appearance:

Affect:

Emotional tone:

Interactions with other students if appropriate:

Interactions with observer:

Participation in the class:

Problems in the setting:

Problems brought to the attention of the observer:

Any additional comments:

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